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MENTAL HYGIENE IN THE ATOMIC AGE *

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FEW current statements are more often repeated and more readily accepted than the assertion that with the construction of a new super-destructive weapon we have entered a new era in history. Popular phrases, if repeated often enough, are likely to be accepted without further thought. The quaintest political figure of our times, a shrewd, ignorant psychopath, who puzzled the world by becoming the leader of the same nation that gave us Goethe, Beethoven, Helmholtz, and Einstein, with the uncanny intuition characteristic of certain psychopaths, discovered the truth that even the most absurd lie will be believed if it is repeated again and again. How much more readily will a statement that contains a kernel of truth be accepted without criticism if it is read constantly in our daily papers, our literary magazines, and if we hear it day by day convincingly expounded over the radio and from public platforms?

First of all I want to question the validity of the statement that, with the construction of a bomb based on a chain reaction in which intra-atomic energy is mobilized to a sudden discharge, we have entered a new era of human history. I am ready to believe that as soon as we are able to utilize the same atomic forces for constructive purposes in industry and in healing, we shall enter a new era of civilization. At present, however, it is by no means certain that we ever shall enter this new era. Our political and military

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leaders insist upon controlling atomic research in order to preserve the secret of the bomb, which they consider essential for our safety. Whether they are right or wrong, as long as this policy prevails, we shall not enter the Atomic Age, for the reason that scientific research requires complete freedom of individual initiative. It is more likely that, paralyzed by mistrust and fear of one another, we shall regress into the darkest phase of human history.

The Atomic Age is perhaps around the corner; but before we can enter it, certain profound changes must take place in the world. I mean primarily psychological changes, changes in our attitudes. The stark question we are facing is: Shall we be able to accomplish this psychological—or, if you prefer it, moral—act of reorientation? At present we are not entitled to speak of the Atomic Age as if we had already entered it. We are standing at the threshold of a new era, with our destiny completely undecided. Calling this era the Atomic Age clouds the most important issue—blinds us to the fact that we still have to accomplish something that is as difficult as the understanding of atomic structure; I mean a profound change in human relationships.

The dilemma we are facing should not be difficult to solve if all people concerned would deal with it on a rational basis. It has been repeatedly emphasized by scientists, statesmen, religious leaders, and educators that the construction of the bomb is a grandiose *reductio ad absurdum* of war. According to the opinion of all experts, the bomb cannot for long remain a secret. No matter for what aim wars are conducted—for material gains or in defense of certain ideals and principles—the primary aim of war is always victory. As soon as the bomb becomes known to other nations, the victory of any one nation becomes impossible or so costly that it loses its meaning. War, then, becomes an insane act of self-destruction. The only rational conclusion, therefore, is that the bomb, and war as an instrument of settling international controversies, should be banned.

Unfortunately, however, human affairs cannot be worked out entirely on a rational basis because man is only a partially rational being—he has not yet earned the euphemistic epithet "*sapiens*" given him by zoölogists. The current controversy between scientists and political leaders is based

on just this simple, but fateful, fact. The scientists have recognized clearly the irrationality of atomic warfare, because its aim, victory, is an impossible achievement for any who take part in it. They insist, therefore, that the bomb, and with it war, should be shelved forever.

Political leaders, on the other hand, are less precise in their reasoning; they know less about physics, but more about people. They observe the already menacing shadows of impending conflicts between the Big Three. They know well that these conflicts do not come from a real clash of economic interests, but from false prestige, rivalry, fear, and mistrust. They know that they must take into account these irrational factors; they cannot discard them merely because they do not conform with abstract reason. Knowing as they do the irrationality of international politics, the position of the scientists appears to them naïve and estranged from political reality. What is the use, they say, of proving with mathematical precision the irrationality of atomic warfare? They argue, moreover, that the bomb is still our secret and that we can use the two or three years during which we have this advantage to strengthen the United Nations Organization to serve as the basis of enduring peace.

The scientist's reply is that keeping the secret will in the meantime create so much mutual mistrust and fear that this in itself will prevent peaceful agreements and organization of international affairs. Why not, they say, follow the dictates of pure reason and insist upon immediate action: that all nations ban war and the bomb *now*?

The answer of statesmen and military leaders is: How can we disarm ourselves in a world full of hostility? How can we control what the other nations are doing in secret? Our peaceful attitude is not shared by others. We cannot trust some neutrals and even some of our allies, not to mention conquered enemies.

And so the argument goes back and forth endlessly, without ever approaching a solution, for the simple fact that the logic of reason and the logic of emotions are acting at opposite poles.

I do not suggest that psychiatry and its preventive application, mental hygiene, can solve this problem. We psychiatrists are too well acquainted with the power of irrational

emotions in shaping the fate of individuals and of nations. We not only have respect for the power of irrational motivations, but we know also how difficult it is to enforce the rule of reason even in our dealings with a single individual. There is no time to psychoanalyze nations or even their leaders. The tempo of technology is faster than the tempo of psychiatry. We can never catch up with the ever-changing conditions science creates almost every year with its spectacular advances. But the human material we deal with to-day is the same as that which fought its irrational battles—motivated by fear, superstition, envy, lust for vengeance, and false pride—with bows and arrows, with armored phalanxes, with guns, tanks, aëroplanes, rockets, and atomic bombs. The weapons have changed, but those who employ them remain the same.

It is only in the last fifty years that the dynamic structure of the human personality has been subjected to detached scientific scrutiny and that methods—still laborious and crude—have been worked out by which in suitable cases certain permanent changes in personality can be achieved, thus enhancing the control of reason over behavior. It is obvious that a change of orientation in international and in all social relations cannot be expected from this type of individual case-work. Technology, however—particularly war technology—has created a dilemma that requires an almost immediate change of attitude among people. To bring about such an immediate and universal change lies quite outside the scope of psychiatry, mental hygiene, or even education. We must agree with Einstein that at present our only hope is that mutual fear will activate the forces of self-preservation and bring nations to their senses to the end that they will accept parliamentary procedures for settling their controversies.

The function of psychiatry and its preventive application, mental hygiene, is a long-term affair. To visualize its development in the future, we must project ourselves into a state of affairs in which we shall have successfully passed through the critical years now ahead of us by having created an effective international organization on parliamentary principles which, at least for a period, will insure peace among nations. Without such an optimistic assumption, we

cannot speak of the future of mental hygiene, because there will be no place for mental hygiene or for anything else that is a part of our present civilization. Assuming a favorable course of events, we can predict with a great amount of probability that social developments will progress along the lines that prevailed in the last hundred and fifty years. I mean that there will be a continuation of rapid technological progress. In this the industrial and medical utilization of atomic knowledge will most likely have a major part. Thus, we shall be exposed to the same problem, possibly in an even more acute form than at present—the problem, that is, of adjusting our social attitudes and international relations to the continuous changes brought about by advancing technology. The atomic bomb is only one spectacular example of a sudden new fact created by science to which we must adjust ourselves. Even after we have solved the problem of war, we shall have to face the problems of peace—problems of which we have had a foretaste in the last decades.

The central psychological difficulty of our industrial era consists essentially in the need for rapid adjustments to ever-changing conditions. In times of slow social change—as, for example, the eight hundred years of the feudal era in Europe—individual adjustments are supported by tradition, as represented by attitudes in the family and in institutions like school and church. By these traditions, tested in subsequent generations, the life of every one is rigidly determined. A glance at the contours of history in the last one hundred and fifty years presents us with a sharp contrast to this picture. With the Industrial Revolution, a fundamentally new era of civilization started, characterized by change and mobility.

It is, however, erroneous to limit the Industrial Revolution to the last decades of the eighteenth and the early part of the nineteenth century. Since those days we have never ceased to live in the era of industrial revolution, if we define the latter as sudden social changes resulting from the rapid advancements of technology. Seen from a distant historical perspective, we still live in the aftermath of that great social movement called the Renaissance. Most people think of it as a movement in art and literature,

but it was much more than that. It was the disruption of the highly organized feudal system by a new fluid social organization which restored social mobility to the individual—freedom of thought and inquiry, freedom of taste and of the senses, freedom that man had lost progressively since the decline of the Athenian democracy.

The most revolutionary result of all these restored freedoms was the unhampered development of scientific thought. At first astronomy and physics blossomed, later chemistry and biology. All this culminated in the Industrial Revolution. From then on, for about one hundred and fifty years, there has been a constant progress in technology which has now reached a new milestone in the beginning of the mastery of intra-atomic forces.

We have no methods to measure precisely the speed of social change, but it is certain that the rate of this already rapid change has been greatly accelerated in our present time. Our habits and views, our knowledge of yesterday are out of date to-day, and it seems that the demand for adjusting ourselves to an ever-changing world exceeds our adaptability.

The birth of this nation coincided with the beginning of the Industrial Revolution. The American pioneer could turn to technology in his heroic task of conquering a vast, unexplored country. Just as the Spanish Civil War was a rehearsal for modern warfare, the conquest of the American continent was a grand rehearsal of modern technology—at first steam, then electricity, and eventually the combustion engine and electronic devices. The utilization of atomic energies will be the next step.

The hero of this development was first the settler, in his steady movement toward the West; later the businessman, the mechanic, and the practical inventor; then the entrepreneur; and finally, in our days of mass production, the organizer, the industrial executive. It is quite natural that worship of the industrial production and distribution of manufactured goods throughout the whole industrialized world should have become the ideological backbone of our times. A part of this cultural climate is the competitive spirit which has played such an important rôle in stimulating production and business in general. Accomplishment became the measure

of public esteem, and accomplishment, for the majority, meant the production and distribution of economic goods. And this production has gradually become an end in itself, overreaching its social usefulness.

I know that this statement is challenging and requires further validation. At first I shall try to demonstrate this cultural trait as it reflects itself in the attitude of the individual toward leisure—the opposite of accomplishment. Most people, engrossed in their feverish race for achievement, are truly terrified at the idea of leisure or inactivity. When the businessman successfully reaches his goal and can stop expanding his business, he does not dare to do so lest his life become completely empty and senseless. Most of us behave like the tourist who takes a trip, but concentrates only on driving his car. The places he includes in his itinerary are only illusory goals. When he arrives at a place, he scarcely notices it; he arrives in the evening, goes to his hotel, sleeps and eats, and starts out early the next morning in order to make the scheduled number of miles to the next stopping place.

I can best illustrate the psychology behind this driving for its own sake with a clinical condition that can appropriately be called "retirement neurosis." I see an amazingly large number of these people. Such a patient is, as a rule, a successful businessman between the ages of fifty-five and seventy. For some reason he has had to withdraw from active participation in business. His reaction is severe depression; life has ceased to have any meaning for him.

The typical life story is that around the age of thirteen or fourteen he started selling newspapers or working as an errand boy. From then on his life has been concentrated on one single goal—financial success. Business has become a passion with him—an all-absorbing, mad race. To the psychiatrist's remark that now, when he has to quit business, there might be something worth while left for him to do in life, the typical reply is: "Doctor, I've never read a book in my life—I've never gone to concerts—and I never could stand a vacation longer than ten days. After three days spent on a beach, I would feel an unbearable restlessness. Soon I would find myself in the hotel's stock-exchange room, next day I would call my firm long distance—and from then

on I could not wait to be back in my office again. And now I'm expected to take a vacation for good. I simply am not prepared for it. I know only one thing—work. If I can't work, I prefer not to live."

One may raise the objection that these are exceptional cases—that for the majority, life consists in a continuous effort to raise their standards of living. The embarrassment people feel if confronted with the question of what to do with their leisure time is, however, universal, a typical feature of our day. It is not so conspicuous in those who are struggling for existence, but it becomes manifest as soon as the necessity for struggle or the opportunity for the improvement of material standards disappears.

We tell ourselves that we are striving for a state of affairs in which the material benefits of our technical advancements will be available to every member of society. Since we have not yet arrived at such a universal state of prosperity, we can evade the embarrassing question: What will then be the content of life for people who have learned only how to struggle for such high material standards, but are not prepared to use their prosperity for the enrichment of their lives? We look with complacency on our great material achievements and overlook the fact that while we were achieving these things, we forgot the elementary art of living. We look condescendingly on the peasants of the feudal era because of their primitive material standards and we overlook their superior capacity for creative expression in folk art, music, dance, handicraft, and folklore, the absence of which makes the life of our industrial masses so drab and colorless.

I do not want to be misunderstood. I am not praising the bliss of feudal culture in contrast to industrial civilization. My point is that while we were busy improving the material foundations of life, we became so engrossed in this endeavor, so fascinated by the possibilities that the machine offers, that we forgot the ultimate aim of all these improvements—a higher cultivation of our specifically human faculties. Eating, sleeping, and propagation are common to men and animals. Division of labor, the exchange of socially useful services, can be observed even in an insect society. But writing poems and novels, building cathedrals, producing

plays and operas, discovering the laws of nature and inventing methods of healing, enjoying a landscape, educating and developing the powers of the mind, are specifically human faculties.

There is good evidence that these human faculties developed as a result of man's invention of the tool. It may be that when a new division of function developed in the organism—namely, the use of the front extremities as arms and hands and not merely for locomotion—this made possible for man a greater measure of experimentation with objects. The differentiation of the hand as a separate specific organ, relieved from its function of locomotion, together with a highly developed cortex in the brain, the site of the highest intellectual functions, made the discovery of the tool possible. From then on, the use of tools opened the road to an easier life and freed human energies for those higher functions which I have designated as "specifically human."

And now we are witnessing a curious turn in human development: the tool, originally developed to enable us to raise our heads and turn away—at least occasionally—from the struggle for existence, has become our master. For its sake, we are giving up the use of our higher faculties, our higher interests, and are devoting ourselves to improving the machine without ever enjoying its real benefits. We have been so preoccupied with the job of building a home through all these years that we have forgotten that we built it to live in. The industrial production of goods has become almost a form of idol-worship with us. We are so absorbed in producing for the sake of production that we forget that the material goods were meant to make us free from the chores of material existence so that we might do something else. As a last result of this nonsensical development, we are faced with the ghastly prospect of using the tool to destroy one another, together with all that we call civilization. Man invented the tool to make life easier for himself; he ends up using it to debase himself to a button-pushing automaton whose last act will be to push the button that will exterminate him.

Nothing illustrates more clearly that we consider production not as a means to an end, but as an end in itself, than our customary approach to the most disturbing symp-

tom of our times—unemployment. With the continuous improvements of mass production with its labor-saving devices, industrial and agricultural goods can be produced with less and less human labor. The fundamental function of the tool is the saving of human energy, and it is only natural that, with the continued improvement of self-regulating tools, the need for human labor diminishes. In itself this should not be a disturbing fact, since man invented the tool just for this very purpose—to secure the necessities of existence with less effort. Human energies thus saved could turn to other purposes. And, indeed, science, with its steady advancement, is creating new industries and with them new industrial jobs.

The experience of the past decades, however, has been that the speed at which the need for human labor has been reduced by technology is much greater than the speed at which new jobs in new industries are being created. The conventional remedy for this is to expand the market by creating prosperity through higher wages.

It is obvious, however, that even in the fairest social system, this extension of the internal market has its natural limitations. As soon as this limit is reached, the only hope of averting unemployment lies in the imperialistic or competitive acquisition of foreign markets. Undoubtedly, with the rapid trend toward industrialization all over the world, this possibility for the expansion of production will soon be exhausted. Moreover, as we well know, the desperate competitive struggle for foreign markets has been one of the traditional causes of war.

The inherent logic of all this is inescapable. The machine was invented to save human effort, and it does and will accomplish its function unfailingly. It is true that labor thus saved can be directed into new fields of production, but gradually more and more will be accomplished by robotlike machines, mechanisms like those we have witnessed during war in the form of self-regulating torpedoes and aërial missiles. The manipulation of the industrial machines will require less and less human assistance, and the use of atomic energies will further reduce the need for the labor that is now engaged in supplying the sources of power. All economic devices notwithstanding, such as better and wider

distribution of products, we shall still have to face the unavoidable consequence—the replacement of more and more human labor by the machine.

The conclusion is inevitable: human effort that is replaced by mechanical devices must find other socially useful outlets, which do not consist of the production of agricultural and industrial goods or their distribution. The whole impasse comes from the bias that the only socially useful activity possible for most people is producing and distributing industrial and agricultural products. It is obvious that if more food is produced than can be consumed and exported, the surplus must be destroyed. The same is true of industrial goods. In a complex society, however, there are other socially useful occupations open to people—all those services that men render to men to increase not their material welfare, but their knowledge, to improve health and make life richer and more enjoyable. And yet we are so used to thinking of jobs primarily as work in agriculture, in a factory or a store, that we cannot imagine any other worth-while activity for the masses.

We are caught at present in a most dangerous form of cultural lag, a fixation to attitudes belonging to an earlier phase of our national history. During the days of pioneering, of unlimited economic expansion, this passion for producing material goods was most appropriate. It was then that the material foundations of civilized life were laid down. Production could not have been overdone. There was never enough of it. At the same time writing poetry in a frontier community surrounded by wilderness was out of place. The youth who loved music and poetry or who was interested in any abstract field was justly considered a misfit.

But the one-sided preoccupation with the material prerequisites of civilization in the midst of a settled and sophisticated society is just as much out of place. A wild and blind passion for producing things of which there is plenty can become a most dangerous passion, as we all should know from not too remote occurrences in our economic life when we enjoyed a few years of pseudo-prosperity.

And it is equally dangerous to try to adjust the economy of a country to this excessive passion for production by artificial economic measures. Artificial employment by gov-

ernment projects, the slogan, "If private business cannot supply jobs, the government has to do it," is obviously not the answer. The question is not who should give employment, but what type of employment it should be. If there is a natural need for labor, it is a secondary question whether the government or private industry employs it. In fact, if there is a real need for labor, the question of government employment does not even come up. And if there is no need for labor, the artificial creation of jobs is economically harmful. Business cannot afford it and government can do it only at the expense of the taxpayers, thus impairing the economy of the nation through increased taxation.

Such suggestions as that of supporting small business at the expense of big business also miss the real point we have to deal with. If the material goods we need can be produced better and more cheaply by big business, it is nonsensical to support small business artificially. This is the same thing as creating jobs that are not needed. It is putting the cart before the horse. We do not want more business for business' sake, more production for production's sake, but as a means of fulfilling human needs. If these needs can be met with fewer jobs, it is illogical to do it artificially with more jobs.

All this boils down to the fact that unemployment is just as much a psychological and an ideological issue as an economic one. That is the reason why I venture to discuss it. Our ideas as to what should be considered an economically productive occupation are warped by our one-sided preoccupation with the production of material goods. In a time of industrial abundance, we are still living emotionally according to the tastes and attitudes that were developed in times of scarcity and of primitive struggle against nature.

Some of you may object to my expression "industrial abundance" as particularly inappropriate at the present moment. I am, however, talking of an economic trend in our time. I am not overlooking the fact that the basic needs to-day are universally not met, as the suffering and starvation of people in war-torn countries amply testifies. Production *is* needed now in a great measure. The production of all kinds of material goods and the distribution of those goods must be improved if we want to relieve the need of

millions of people all over the world who are at present crying for help. This, however, is obviously a transitory situation, the immediate result of the war. If we project ourselves into what is called the coming Atomic Age, an age of further technical perfection, we have to visualize an era of industrial abundance. The psychological problems of this coming era, which, considering our industrial potentialities, should not be far away, are the concern of my discussion.

Social life consists in the mutual gratification of human needs by a division of functions. It makes no difference what those needs are, whether food, or shoes, or lounging chairs, or poems. As soon as the needs of the body are satisfied, the satisfaction of our so-called higher needs must become our concern. Why should we consider the production of lounging chairs more basic than that of poems when one can exist equally well without either of them? And yet the production of lounging chairs is considered productive, increasing the national wealth, while poetry, from the point of view of economics, is quite negligible and has nothing to do with increasing the national wealth except possibly through the paper on which it is printed. Yet if more people were interested in buying poetry than in buying lounging chairs, it would become a much more important item in the national economy than the chairs.

The answer to this problem lies, then, in ideological changes—in a different scale of values appropriate to the phase of our social development. A country that has succeeded in such an unparalleled manner in laying down the material foundations of civilized life is ripe for taking the next logical step in its development—the building of a high spiritual culture upon the material foundations. Productive energies can no longer concentrate exclusively on continuing to build the foundations because to a large extent they are already laid down. Systematically we shall have to develop needs for less tangible goods which cannot be produced by machines.

This can be done only through education of the masses, with a greater emphasis on the liberal arts and on the merits of æsthetic appreciation and creative expression. Moreover, human energies can more and more turn toward such channels as teaching, healing, and all those human services that

make for the enjoyment of life. Human energies liberated by advancing technology must be used either constructively or destructively. The choice is ours. If greater attention is not paid to cultural and moral values, it will lead to our destruction—either moral or physical.

Neither national nor international problems can be solved from a purely economic point of view. We must free ourselves radically from the one-sided over-valuation of the production of material goods, the heritage of the early phases of the Industrial Era. This part of our life we must begin to take almost for granted. The strange thing is that if we apply these same principles to the human organism, we find them self-evident. We readily admit that the vegetative functions of the body—digestion, breathing, evacuation—are not the aim of life, but only the means of living; that our so-called higher interests—our hopes and ambitions, our self-expression, our human reactions—are what we are living for. We accept the fact that the vegetative processes of the body take place automatically and require almost no conscious attention on our part. It is only when we are sick, when they fail, that our attention is called to these functions. But when it is said that the same thing is true for society—that industry and commerce will, due to organization and the further development of machines, become automatic functions and cease to be the center of our attention—we balk as if the very foundations of our civilization were attacked.

Finally, we must realize that we are misusing our technical knowledge not only if we wage war, but also if we do not use the energies freed by technology for constructive purposes on a higher scale in our national life. We will have to educate our youth not only for the production and distribution of goods, but also for the higher expression of cultural life, for science, and art, and all those services that make for the art of living. The slogan of the Century of the Common Man needs a new interpretation. Once, it is true, this country's rôle in history was to open to the common man of all lands the possibility of a free and prosperous life. But with the years, this rôle has changed. Now it is to enable the common man to be the uncommon man. Advancing technology brings not only advantages, but obligations. We

who have the highest material standard of living in the world must now give heed to our moral standards and to our culture in general, so that the leisure we have insured may be used constructively to the higher development of the potentialities of man.

The aim of psychiatry is to help the individual who has failed to adjust himself to the conditions of his life. Mental hygiene attempts to accomplish the same thing on a large social scale. Like psychiatry, it must begin with a diagnosis of the trouble, finding those emotional difficulties of adjustment to which the majority of the people are exposed. In this address I have limited myself to attempting a diagnosis. My conclusion is that we are the victims of a cultural lag in as much as we still live emotionally in the past and have not caught up with the new conditions brought about by science and its technical achievements. Following the inertia of habit, instead of making use of the labor-saving devices of industry for turning our creative capacities to other fields that lie outside the production of material goods, we are apt to follow traditional patterns, and as a result more people will want to earn their living from industrial production than will be needed. This incongruity between ideology and economy will, with the further improvement of automatic tools, steadily increase in the future. The result will be that periodic unemployment will remain with us as a constant source of insecurity and a constant threat to self-esteem—arousing the feeling of having lost one's social usefulness. This insecurity and the frustration of having no opportunity to make use of one's productive capacities are the main source of emotional maladjustment in our times, taking the place of sexual repression which dominated the scene during the Victorian Era.

Another manifestation of this cultural lag is our addiction to competition, which makes of our social scene a race track. We live in a world of plenty—at least potentially we do—and yet emotionally we still follow the jungle pattern, "Kill or be killed." At home as well as abroad we continue in the belief that it is necessary to prey upon one another. Thus competition within and between nations, even when it is unnecessary because of our mastery of the forces of nature, remains an addiction with us. If we do not have to struggle

and compete, life becomes empty for us, and this feeling is a common cause of emotional maladjustment. We see, then, that no social group can escape the mentally unsettling consequences of the prevailing discrepancy between emotional orientation and social structure. The effect of this discrepancy upon the struggling masses is insecurity, loss of self-esteem, and frustration; its effect upon those who do not indulge any longer in the race for success is a feeling that life is empty and has lost its meaning. Indeed, machine civilization with all its magnificent material achievements, has created a gap in our emotional household by liberating energies that we have not yet learned how to use in a constructive manner. To fill this gap by developing the higher creative faculties of man is the great future task of our era.

I have limited my remarks to defining the nature and source of the most common emotional problems of our times. Making such a diagnosis is one function of mental hygiene. The remedy lies obviously in an emotional reorientation, restoring the disturbed relation between psychological attitudes and social structure. The achievement of this lies not primarily in the field of psychiatry or of mental hygiene. It is the function of the social institutions to which the shaping of the personality and of social attitudes are traditionally entrusted—first of all the family, then the church and the school.

WOMEN AND MODERN STRESS*

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IN undertaking to speak on the topic "Women and Modern Stress," I realize full well the risk that one runs in attempting to deal with a subject so general and so inclusive. There are many varieties of stress, ancient and modern, and it is an undeniable fact that there are many varieties of woman. To speak generically of women as a sex is to lay one's self open to charges of inaccuracy or ignorance. Indeed, it may be that to discuss women at all has its elements of danger. Certainly a mere man, however wise and however experienced, cannot dogmatize on such a subject, and certainly I shall not attempt any sweeping or generalized statements unless it be understood at the outset that any such statements about human beings, male or female, are subject to numerous exceptions.

I shall attempt to outline some of my ideas as to the types of stress that are operating in the modern world, with particular reference to the manner in which women are affected by them. It is my hope that some experience in psychiatry may be of assistance as a basis for these impressions. As a matter of fact, however, there are times when one must doubt whether a physician's views of the human race are not somewhat warped by the fact that by and large it is only the sick and the unhappy who consult him.

This emphasis on illness may tend to obscure the truth that most people make reasonably satisfactory compromises with reality, adjust themselves reasonably well, and are at least moderately happy and healthy. William James, however, long ago pointed out that conditions of gross maladjustment, by presenting exaggerations and perversions, equivalents and substitutes, may enable us the better to under-

* Presented at McGill University, Montreal, Canada, January 16, 1946.

stand the elements of what constitutes what we choose to call normality. "To understand a thing rightly," he said, "we need to see it both out of its environment and in it, and to have acquaintance with the whole range of its variations." There are respects, therefore, in which the experience of the physician may be of assistance in understanding the well and enabling them to retain their health.

When we speak of modern stress, we should bear in mind that stress is universal in time and in place. No one, whether he lived in the time of the caveman or in this year of grace, 1946, is immune from stress at any time. Life, after all, is nothing but a continuing adjustment to stress of one sort or another. Samuel Butler, in his famous novel, *The Way of All Flesh,* summed up this truth with that eloquence and psychological insight which are often the quality of the novelist.

> "All our lives long, every day and every hour, we are engaged in the process of accommodating our changed and unchanged selves to changed and unchanged surroundings; living, in fact, is nothing else than this process of accommodation; when we fail in it a little we are stupid, when we fail flagrantly we are mad, when we suspend it temporarily, we sleep, when we give up the attempt altogether we die. . . . A life will be successful or not, according as the power of accommodation is equal to or unequal to the strain of fusing and adjusting internal and external changes."

Some of these stresses are internal. They result from conflicts between our instincts and what we have been taught to accept as the dictates of society—that is, our conscience or super-ego. Some of these stresses may be due to constitutional or hereditary factors, but the vast bulk of them represent early influences. Others of our stresses are more immediately and clearly environmental. They have to do with the impact upon us of other individuals, either by themselves or as a group—that is, organized society. These stresses may be domestic; they may be financial; they may have to do with one's work, with one's social contacts, with one's school—in short, with any situation in which interpersonal relations are involved.

As civilization has developed, more repressions have been necessary; more limitations have been placed upon the conduct of the individual for the benefit of the group; competi-

tion has become more intense in every field. Life has, in short, become more complicated. For that reason it is probably fair to say that stress is becoming more intense and more varied as society progresses. I use "progress" in the sense only of meaning advancing in time, not necessarily advancing in ethical standards or in general becoming better!

The stresses that operate upon any given individual are at least in some way, and usually in many ways, different from those that operate upon any other; at least if the stress is identical in any two cases, the response is not necessarily so. The conduct of any person at any given time is the result of an interplay between his personality—that is, his anatomical and physiological make-up, his intellectual and emotional organization and the influences to which he has already been subjected—on the one hand, and the immediate stimulus on the other. It is axiomatic that no two people are entirely alike. This is as true of their heredity, their constitution, their temperament, their training, and their experiences as it is true of their fingerprints.

With women constituting about one-half of the human race, it can thus be seen that it is dangerous indeed to generalize about them—even dangerous for a male psychiatrist in what is essentially a masculine world!

When we say that this is a masculine world, we are not indulging merely in an idle pleasantry. It is a fact that most of the advantageous positions in business, in the professions, and in political life are held by men, and that there is still a substantial prejudice against women in most fields, if not in all. As a result, the woman has to accommodate herself to an acceptance of this fact and to sublimate or to repress her aggressiveness, substituting therefor an appearance, at least, of passivity, depending to a large extent upon a pleasing manner and an acquiescent attitude rather than one of too obvious domination. It is a fact, too, partly conditioned by biological peculiarities, that woman is in general more deeply and closely affected by the various *mores* and taboos of society than is the man. It is not at all unlikely that a good deal of what has been commonly assumed to be a fundamental difference in the psychology of the two sexes is largely based upon this response to social pressure

instead of being something inherent, although Helene Deutsch, in her studies of the psychology of women, has cast light on the inherent differences as well.

Whether or not this be the case, it is true that there are certain factors in the social situation that operate differently upon women from the way in which they affect men. This is still the case, even though for the last fifty years there has been a growing recognition of the woman as an individual. Many women have of recent years achieved substantial successes in business and in the professions and some have become reasonably active in the political field. During and immediately following World War I, there was a considerable development of what might be termed "the emancipation of women," and the age of the "flapper" is still remembered by many of us.

We have just passed through another war longer than that of 1914–18, far more grueling in the experiences of the participants, military and civilian, and far more significant in its social influences. A large part of the available man power in the belligerent countries was drafted into the armed services, with the result that women played a large part in industrial activity, some of it, indeed, decidedly heavy work. Certainly, if there had been any doubt before that women could take the place of men in many of the manual pursuits that had formerly been thought to be exclusively masculine, that doubt has been dispelled. The same may be said of the armed services themselves, in which for the first time women were allowed to take a substantial and active part, not only in clerical and hospital activities, but in mechanical ones as well.

Stubborn as were the resistances to the introduction of their services, women acquitted themselves most creditably, making a valuable contribution to the success of the total war effort. In addition, many women who had numerous other responsibilities did yeoman service as volunteers in various lines of activity, such as the motor corps, hospitals, and civilian defense.

Just as the soldier in the field of combat is buoyed up by the support of his own group and the feeling that he is a member of a company commanded by a competent officer, so in the same way the civilian during the conflict develops

an increased feeling of solidarity with the entire social group, military and civil alike. This has a stimulating effect and develops self-confidence, self-reliance, and self-assertion. It is particularly helpful to feel that one is taking an active part by actual participation in the war effort. At the same time it must not be forgotten that war is essentially a destructive process and that no matter how the balance sheet is drawn up, it always has a large balance on the debit side.

There are worries as to one's own immediate safety, at least in those countries in which enemy attack by air, land, or sea is possible; there is anxiety over the welfare of one's loved ones who may be in the services; there is concern over the cost of living, the obtaining of food, clothing, and shelter, particularly for the children of the family. An additional phenomenon which has been observed after every war—and very likely will be observed in greater measure after this one as a result of the increased diversion of parental attention through occupation outside the home—is the rise of juvenile delinquency.

Certainly, in times of conflict, a state of tension seems to be in the air. One operates under pressure, one feels a sense of urgency. All of these factors have an impact upon the individual, and those who are the least well able to stand such a combination of factors may well undergo breakdown more or less serious. There were those of us who looked for a substantial increase in mental breakdowns as a result of the tremendous stress under which the population of the British Isles operated in the darker days of the war, and we were pleasantly surprised by some of the facts presented by Dr. Aubrey Lewis in the *Lancet* in 1942.

On the basis of reliable data from London and Bristol and the impressions of a number of medical observers in various parts of England, Lewis came to the conclusion that after intensive raids there was a slight rise in the total amount of neurotic illness in the affected area, occurring chiefly in those who have been neurotically ill before. He found also that the admission rates to mental hospitals actually showed an over-all decrease, except that more elderly patients were admitted because their relatives could not look after them. Suicide, too, showed a substantial diminution in Scotland. Pointing out the multiplicity of causation of

neurotic illness, Lewis states, "It is to the war as a whole with its accumulated stresses that people have had to adjust themselves, and signs of failure to do this can be taken as warning signals of neurosis."

These observations were not limited to women and, indeed, are more impressionistic than statistical. Very few opportunities, in fact, have arisen to make war-time studies of women as such. One study concerning women has recently been published and may be referred to briefly here. It was made by one of my colleagues at St. Elizabeths Hospital, Dr. Harold Stevens, and appeared in the issue of the *American Journal of Psychiatry* for September, 1945.

During the earlier days of America's participation in the war, a large number of young women were recruited from various parts of the country to accept clerical positions with the government in Washington. The city was seriously crowded; the cost of living was high and few recreational facilities for persons of limited means were available; working conditions in many cases were unsatisfactory, and to many of the girls the entire atmosphere of a crowded city was wholly alien to their previous experience.

During a period of two years—namely, from January, 1942, to January, 1944—89 of these women were admitted to St. Elizabeths Hospital as psychotic patients. There were many others, of course, who underwent breakdown, but for whose immediate return home arrangements could be made without an intervening hospitalization. Three were noted on arrival in Washington to be psychotic and 58 per cent of the 89 women had been hospitalized within less than six months of their arrival in Washington.

One of the very significant features of this group was that 36 out of the 89—that is, more than one-third—had previously been patients in mental hospitals and that nine additional of the women had a clear history of prior mental disease without hospital care. Presumably, if this information had been elicited, most of these patients would never have been brought to Washington by the government. Many of them were making a good adjustment to their situation at home, but were suffering from an instability which had already manifested itself in a favorable environment. They were unable to adjust to the more difficult situation which

they met in their new location. The fact that the breakdowns of well over one-half of the patients occurred within six months after coming to Washington indicates the importance of the factor of environmental influences, but indicates also that the factor of previous instability is fully as important. This truth points to a problem in industrial medicine which may well be expected to become more acute as proportionately more women are employed.

Reference may also be made here to one or two points of interest in an unpublished study of 100 non-officer service women, who were studied at St. Elizabeths Hospital by Dr. Evelyn Reichenbach. Of this group 47 had had previous attacks of mental illness and at least 10 had been psychotic at the time of enlistment. The duration of service prior to the onset of mental illness had been less than three months in nearly one-half of the cases.

In fairness to the women's services, however, it should be pointed out that the proportion of those who became psychotic was extremely small. The fact remains that of those who developed mental disorder a large proportion had shown in civil life, and under reasonably favorable circumstances, their inability to make a satisfactory adjustment.

These two studies are cited partly because material of this sort is relatively scarce, and partly because it reinforces an axiom—namely, that those who are unable to adjust to relatively simple situations are even more likely to fail of adjustment when stress becomes more difficult.

We have already mentioned the fact that many women were employed during the war and that they did their work well. What of the effect, however, of the mother's absence from the home? The fact that the wife was bringing in a substantial proportion of the family income changed her relative position and gave her an increased amount of independence and authority. On the other hand, the fact that both parents were absent, the father often being in the service, often meant that the children had far less supervision than is normally the case. The relative lack of supervision—in addition to the fact that often the children also were earning—tended to promote the adolescent revolt against authority, so that, although financially the work of the mother was helpful, the fact that she was employed has

sometimes been quite disruptive to the family situation. Unquestionably, some women welcomed the freedom from responsibility for the welfare of their children, and cases are not unknown in which the job furnished a very convenient rationalization for neglect of domestic duties.

As an interesting commentary on the subject of the emancipation of the adolescent may be mentioned the emulation of the male sex by some of the so-called "bobby soxers," the girls who prefer dungarees and ill-fitting sweaters to more feminine clothing. This group provides a modern variant, and hardly a preferable one, to the boyish-form flapper of the early twenties. These phases of protest against femininity are, however, usually short-lived.

Another phenomenon of the war has been the startling increase in marriages of young girls, very oft n on short acquaintance. These marriages, which in a od many instances were properly called hasty, probably presented the very prevalent feeling of insecurity. In a uation in which a holocaust of the world was threatene t a time when all values seemed ephemeral and when t return of the loved partner was highly problematical, it was, perhaps, to be expected that the Latin motto, "*Carpe diem*!" should be followed. Perhaps the large proportion of promptly resulting pregnancies may be interpreted as a desire for immortality on the part of the young parents.

Some of the husbands have returned much changed, some seriously ill or injured, and too many have not returned at all, yet I doubt whether any one in this audience is bold enough to say dogmatically that a mistake was necessarily made in following the biological urge. Many of the wives have changed, too, and we may safely expect that a substantial number of these marriages will end in divorce. That will be part of the scene of post-war disorganization. As for the substantial increase in illegitimate births, that, too, is a part of the war picture, with its slackening of inhibitions and the desire on the part of some women, at least, to be as free and uninhibited as is the male.

Now the war is over. Almost overnight we see many of the motivations halted or reversed. Perhaps too rapid an attempt has been made to return to a peace-time status. At any rate, the high and patriotic impulses that held groups

together and that promoted the ungrumbling acceptance of inconvenience and privations have ceased to exist. Who, six months ago, would have believed it possible that large numbers of American soldiers would stage a near riot, holding mass meetings of protest, and boo or "challenge" generals over the question of returning home, when there is still a long job to be done in the line of policing the world? Such a spectacle serves to emphasize the rapidity with which profound post-war demoralization may take place.

With the end of the war, large numbers of veterans have been returned to civil life, with the result that considerable numbers of women have gone back to their homes, the need for employment having ceased or the desirability of re-forming the household having become demonstrable. Other women have been displaced by returning veterans, so that a substantial change has already taken place in the industrial field as regards distribution of the sexes. What effect may this redistribution be expected to have? What will be the attitude of the woman who has been earning substantial wages in war industry, or who has served in the armed forces, when she returns to the humdrum ways of cooking and caring for the family?

Generalization is dangerous, but it seems likely that the majority of women who are married and who have families recognize that their first duty is to the household and to the supervision of their children. They may, of course, regret the absence of the weekly pay envelope, and they may miss the excitement of the contact with others and the relative freedom that they enjoyed, while some undoubtedly will continue to work as long as possible, even though it is no longer economically necessary.

An interesting subject of speculation is what the future results will be upon those unmarried women who have found satisfaction in their work and their pay. Will they choose a career instead of a home, eschewing marriage and children? It is hardly likely that they will deny the biological urge entirely, yet it seems more than likely that the future will continue to bring a somewhat further decline in the birth rate as more women prefer freedom to work rather than the more conventional domestic joys. The woman who has been working, particularly during the war, has felt a satis-

faction in accomplishing something constructive, in doing her share toward the common goal. Now that the conflict is over, that goal does not appear so urgent and it is quite likely that more than some of us think will see fit to return voluntarily, and indeed happily, to the fireside.

The danger of the death of loved ones in foreign lands, the danger of bombing, and most of the problems of rationing have ceased. But as the "old order changes, yielding place to new," new sources of anxiety arise to replace those that have passed. The development of atomic energy has made more urgent than ever before the problems of the prevention of future war, and has emphasized to all thinking persons the completely catastrophic nature of the next war, should one be permitted to occur. The cost of living is showing a rise and promises to show more, a stress that brings in its wake problems of wages, while numerous strikes interfere with employment. The cohesive tendencies of war have given way to instability and restlessness; this is noted in the political field as well, and serves to underscore the prevalent feelings of insecurity.

Many women are apprehensive about what changes, if any, will be observed in the returning veteran member or members in the family and whether those changes will be for the better or for the worse. Let it be said here that some of those changes will be for the better. There is no reason to look upon all returned veterans, or even upon the majority of them, as psychiatric liabilities. Many of these men have been matured and seasoned by the difficult experiences through which they have passed. This, of course, is not to say that all of them will be without problems; a measurable proportion of them will be psychiatric casualties, more or less severe. It may well be, on the other hand, that the housewife to whom the veteran returns has also been matured by her experiences, and that they will work out better and more successfully than they did before their mutual and individual problems of adjustment.

Enough has been said to indicate the nature of some of the stresses to which women are subjected at this time and some of the changes in type of those stresses that have taken place recently. What are the individual's reactions? What sort of symptoms may we expect in the person who

is undergoing some difficulty of adjustment to the strains that impinge upon him from without? They are relatively undifferentiated, but common and familiar to nearly every one in the course of his experience. They differ in degree and intensity, as well as in the number that any one person may exhibit.

When we say that they are common, or vague, or undifferentiated, we do not mean to imply that they are not troublesome, annoying, and sometimes highly disturbing, both to the person who suffers from them and to those who come in contact with her. Perhaps one of the most common is a feeling of tension, something that is hard to define and yet that we all understand, a sensation as if one were wound up too tightly, as if one could not relax. Not only is the voluntary musculature tense, but there is evidence of overactivity in the autonomic nervous system, as indicated, for example, by various gastrointestinal symptoms or by a heightened pulse and blood pressure.

There is, too, a feeling of restlessness accompanying this tension—a psychological tension, as it were, which causes one to feel vaguely apprehensive, to respond with undue readiness to stimuli, to be irritable upon slight provocation, restless and overactive. "Fidgety" is perhaps the adjective that describes this state of mind clearly, even if colloquially. Relaxation for the purpose of sleep is difficult. Sleep, when it comes, may be light and restless and accompanied by disturbing dreams. Concentration is poor and it is difficult to sit down comfortably to read a book, for example, or to carry on a quiet conversation.

Accompanying this tenseness and constant discharge of energy, there is often a feeling of fatigue. The subject wakes up in the morning tired and feels tired throughout the day, even though she may have spent the usual number of hours in bed and not have engaged in physical exertion. There may be disturbances of appetite or of bowel function which add to the uncomfortableness of the patient.

These symptoms, then, are relatively simple, yet the totality of them may serve merely to increase the anxiety and the tenseness of the patient, so that we find a vicious circle. One of the manifestations and one of the attempted cures may be excessive smoking. This nervous smoking is, I think,

a good deal more common among women than among men, although there is no doubt about the prevalence of the practice among the male sex. Whether it be that in cigarettes the amount of nicotine is extremely small on account of the quick combustion, or whether the sedative effects of tobacco are overestimated, it certainly does not seem that smoking exerts a particularly sedative effect upon patients who are showing this form of restless reaction.

In conditions of tenseness a resort to alcohol is not at all uncommon. Statistics on drinking are notoriously misleading, so much so that even the citation of them sometimes appears to be an insult to the intelligence of the listener. There is a general impression, however, that during the war and in the period immediately following there has been a very substantial increase in the consumption of alcoholic beverages, largely of the spirituous variety. This resort to alcohol is dangerously easy. Although the average well-adjusted individual can use alcohol in moderation, there certainly are many persons who, by reason of their inability to cope with the situation, should not indulge in it at all. Although alcohol has its social advantages, it is a dangerous drug from a therapeutic point of view. Certainly, as a remedy for neurotic tension, it serves to aggravate rather than to relieve.

The same may be said as emphatically of the use of sleeping pills. There are drugs of a sedative nature that will produce sleep, but a resort to them merely covers up an underlying situation that needs attention. It is for this reason that in most of the American states a physician's prescription is required in order that one may purchase drugs of this sort. Self-medication of any variety is dangerous, and this type is no exception.

What are some of the methods that may be adopted to relieve tension and to prevent it? General physical hygiene is, of course, highly desirable. Observations made during the recent war have indicated that it is when men are in a state of extreme fatigue and suffering from hunger and thirst that they are the most vulnerable to psychological stress. The same is true of any one in a civilian milieu. Adequate rest, a well-varied diet with adequate vitamin intake, moderation in the use of alcohol and tobacco—all

these are desirable as generally building up one's ability to cope with difficult psychological situations. A reasonable degree of confidence in those about one and a broad toleration of the peculiarities of one's friends are relaxing and hygienic frames of mind. One needs above all a scale of values with relation to one's self. The late Dwight Morrow has been quoted as having a rule that he considered important above all others—namely, "Don't take yourself too seriously." Recognition of the fact that, important as the individual is to himself, he is hardly the center of the universe, and that when he does his best to conduct himself in the manner that will be most helpful and least troublesome to others, he has done his part, without taking on responsibility for the shortcomings of others—this attitude does much toward promoting peace of mind.

One must recognize that conflict is a part of life and must be ready to deal with difficult situations as they arise with a minimum of evasion or postponement. The development of hobbies and interests outside one's immediate occupation is a highly important thing which has been too little stressed and unfortunately too little developed in our educational program. Much might be said, indeed, about the manner in which our educational scheme has been organized. If there is anything in psychiatry of which we are reasonably sure, it is that many attitudes that follow us through life develop in the early years. An extraordinarily large proportion of teachers appear to have little or no sense of responsibility for the emotional poise of children. Many of them have no training whatever to meet this need, and some of the teachers certainly are mental problems to themselves. The importance of training teachers in the principles of mental hygiene and expecting them to take as much interest in this as they do in their functions is an important need of pedagogical training. When this truth is more widely recognized in our teachers' colleges, we may safely expect to have a younger generation that will be more ready to face the "slings and arrows of outrageous fortune" than is the case to-day.

It should not be inferred from what has been said that all forms of nervous tension are brief, or that all of them are responsive to the methods of attack that have been sug-

gested. Although it is true that fundamentally the patient must resolve his own conflicts, it is likewise true that the assistance and guidance of a trained and understanding person is sometimes necessary to guide the subject upon the right path. Too often ruminations and the reading of various popular books on self-cure are likely to result in a further involvement of the psychological labyrinth rather than a clearing of the path. It is the psychiatrist's function to be helpful in these situations, and there is no reason why one should hesitate to consult a psychiatrist if one feels that one is in a state of tension that is not responding to one's own attempts at solution.

This advice is applicable also to those problems that result from various sexual tensions. Even though the generally accepted views on the relations between the sexes are far more tolerant than they were twenty-five years ago, controls, inhibitions, and sublimations are necessary socially and psychologically. These problems are more easily worked out with the aid of sound professional advice than by the costly method of trial and error.

Probably most of what I have said sounds old and familiar; it should—at least I think it is true. As Lord Horder said, however, in a lecture on "The Hygiene of a Quiet Mind," several years ago (1938), "It is easier to get a hearing for things that are new than to get conviction for things that have been said already." The problems of living successfully are always with us, and there is no royal road to their solution. Friends, satisfying work, security, agreeable hobbies, good health—all of these are valuable, but above all, man or woman, young or old, soldier or civilian, we need a readiness to face reality, an ability to rely on ourselves. Given these, even the stresses of the difficult times in which we live may be faced with assurance.

GROUP PSYCHOTHERAPY WITH VETERANS*

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THE Red Cross Rehabilitation Clinic was established by Dr. Robert McGraw, of New York City, in 1944. It was designed to provide diagnostic and therapeutic services for war veterans discharged for psychiatric reasons. The reason for introducing group psychotherapy as a special service was twofold: first, the psychological and social problems of veterans reëntering civilian society have certain common features; and second, the large numbers of such men and the scarcity of psychiatric personnel seemed to warrant the use of a more economical method of treatment, such as the group approach seemed to represent.

In instituting group treatment at the Red Cross, I was under no illusions as to its special powers. Up to the present time, there have been few reports of controlled clinical observations of the application of this method to adult patients. The method is still in the exploratory stage and no definite statement can yet be made as to its value.

In my mind, there are three central questions to be asked regarding this method: To what extent is group therapy an experience in social reëducation? To what extent is it a real psychotherapeutic instrument, and for what conditions is it best suited? How economical is this method, if properly used?

On the basis of some previous experience with this method, I felt that its experimental application to the personality problems of veterans was justified. In initiating the experiment, I guided myself by a set of tentative hypotheses which I was prepared to modify with increasing knowledge. These are as follows: Group psychotherapy neither substitutes for

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nor competes with individual psychotherapy. It is in some respects an independent method with certain unique dynamic characteristics of its own, and it serves certain special purposes. For adult patients with serious intrapsychic distortions, it is either contraindicated, or represents, at best, a partial therapy.

Group therapy is a laboratory in social living. It is a special kind of social experience and may bring about effective reduction of certain socially deviant behavior patterns. The interpersonal relationships within the group are experienced on a more realistic level than is the case in individual psychotherapy. The group relationships offer direct gratification of certain emotional needs—for example, the need for acceptance and for satisfaction of dependent strivings. The group setting is more specifically adapted to patterns of emotional conflict that are externalized—that is, in which the zone of friction is mainly between the person and the environment rather than between two opposing forces within the psyche. Group dynamics enhances the expression of emotional drives that can be experienced in common. It encourages an actual living out of these emotional experiences and tends to release tension on a motor level.

It was my intention to employ the group method, concretely, as a psychotherapeutic instrument. I planned to exploit, as far as possible, the special effects of group psychological phenomena rather than simply to apply, unmodified, the procedures of individual psychotherapy to the group situation. It was my object to relieve anxiety and guilt, to resolve conflicts, to modify attitudes, and so to improve the level of social and occupational adaptation. In general, the emphasis in therapeutic focus was on the pathology of social behavior, on the external aspects of behavior, rather than on intrapsychic aspects.

In accordance with these general principles, I wished to select mainly patients with milder conditions in whom disturbances in social attitudes and behavior were a conspicuous component. I selected men from the following categories: (1) social maladaptation, with a large reactive component; (2) character disorders of the milder type—for example, shy, timid personalities, overaggressive types, and passive,

dependent types; (3) true combat neuroses, with no previous psychiatric history; (4) psychosomatic disorders, representing recent, acute, and reversible disturbances, such as insomnia, headache, fatigue, and certain conversion symptoms.

Because of the pressure of circumstances, however, I was compelled to admit into the group, also, some chronic personality disorders not included in the above categories—specifically, obsessional neuroses and pre-psychotic personalities. I did not expect to achieve a cure of such conditions, but hoped, at least, that the associated social disturbances might be favorably modified. Beyond that, I was interested in seeing just how much help these men could derive from a group experience.

When applied concretely to the problems of veterans, such criteria, exclusive of the few exceptions indicated above, translated themselves into a group of men who were unable to bridge the gap between military and civilian society because of social maladaptations or deviant character traits that prevented flexible adaptation to changing social conditions. These were men who had returned to their home communities with heightened irritability, emotional instability, and confusion, with vacillating social values, with dissatisfaction toward their opportunities in civilian life, with a failure to hold jobs, with attitudes of exaggerated demand and suppressed hatred, or with reactions of shame connected with their discharge from the armed forces. For example, some were loath to surrender their uniform or ashamed to show their faces at their old jobs.

Before admission into the group, each man was examined medically and psychiatrically. Where indicated, psychometric, Rorschach, and vocational-guidance tests were given.

In order to insure effective emotional contact between the patients themselves, and between them and the therapist, and also to provide conditions favoring dynamic continuity in these relationships, the group was restricted to a maximum of seven men.

To provide a proper balancing of dynamic forces within the group, I included some timid and some aggressive personalities. To provide an adequate basis for rapport between the men, a basis for mutual emotional interest and communica-

tion, patients were selected who had certain common psychological difficulties, although in other respects there were distinct contrasts in personality.

Therapeutic sessions were held once a week and lasted one and one-half hours. This represented an arbitrary arrangement dictated rather by reasons of expedience than by the patients' needs. The men themselves expressed a strong urge for more frequent sessions. Individual interviews with each patient were held at irregular intervals.

In order to study the patients' reactions, verbatim notes of the entire proceedings were recorded by a stenographer, who sat in the room. Since this was exclusively a male group, this procedure introduced a special influence, the effects of which had to be taken into account, particularly as regards sexual reactions.

In all, there have been thirty-five such sessions up to the present time.

I introduced the men to this new experience by outlining in a brief, simple statement the aim and method of this form of treatment. The sense of this was as follows: All of the men had been soldiers. They had done their best, but were now out of the armed forces because of nervous difficulties. There were certain common features in these varied nervous reactions. All the men had anxiety. All had experienced emotional suffering of one form or another. Some had physical complaints, which were products of anxiety. Many of them had personal problems and conflicts which they had been unable thus far to solve. All of them faced the task of reëstablishing their places in their families, in civilian society, and in industry. They had experienced difficulty in shedding military habits and in returning to civilian modes of behavior. Our purpose in coming together was to discuss freely these problems; to express candidly feelings, conflicts, confusions, and anxieties; and to attempt through mutual help to achieve a more effective understanding of these disturbances. In this way, it might be possible to relieve emotional suffering, solve personal problems, and live with greater efficiency and satisfaction. The discussion was to be entirely informal and spontaneous. They could talk at will, but were asked to be completely frank.

My therapeutic aims in using the group method were, concretely, as follows:

1. To provide emotional support through the group relationships.
2. To activate emotional release in the area of specific anxiety-ridden conflicts; in particular, to encourage the release of pent-up aggression. This meant utilizing group influences for the selective reënforcement of some emotional trends and the dilution of others.
3. To reduce guilt and anxiety.
4. To provide opportunity for the testing of various forms of social reality as personified in individual members of the group as a whole.
5. To provide opportunity for the modification of the concept of self in the direction of increased self-esteem and recognition of constructive capacities. This in turn tends to increase the acceptance of other persons and tolerance for frustrating experience.
6. To foster the development of insight arising from an actual living out of emotional drives in the context of the multiple relationships within the group. The technique of interpretation was employed only when the expression of specific emotional trends was sufficiently solidified.

I shall give now a brief description of the activity of such a group. Generally, one patient assumes the initiative in presenting his personal problem. After that, others imitate. They relate similar experiences, or present contrasting ones. They interrupt at will, ask questions, express disagreements, offer criticisms or advice. They attempt to help solve one another's problems.

A feeling of belonging to the group is soon felt to some extent by all the patients. The wish to receive and to give emotional support is mobilized through the relationships formed within the group. This is of tremendous importance to these men since they are frequently troubled by a sense of emotional isolation, especially in the early phase of transition from military to civilian life, and in the case of men who suffer from a lack of close personal and family ties. On this background, the group represents to some a substitute family life. This is the supportive aspect of group therapy. The

men use the group to achieve a dependable social reality, which all too frequently is lacking in their real lives. Because of this lack, their values tend to remain confused and conflicted.

The patients unburden their personal problems, frustrations, and anxieties. They release their pent-up feelings. This release becomes progressively heightened and, at times, rises to an intense pitch. Feelings are "acted out" with a high degree of freedom. Some types of emotional drive are reinforced, others inhibited. Dependent wishes, exaggerated demands, and specific patterns of hostility are released. Specific conflicts, with the related guilt feelings and anxieties, are expressed and clarified. In releasing these pent-up drives, patients use the group as a sounding board for testing the real meaning of their impulses and the validity of their particular concepts of social reality.

In comparing conflicts and fears, there is a strong tendency to find common denominators, and to reduce the problem to a level of common psychological difficulty. This is an inevitable trend because of the emotional unity of the group. Differences between individual members are held in abeyance temporarily while an effort is made to solve a common conflict or fear. Each person is stimulated to a fuller consciousness of his own emotional disturbance, and attempts to discern its real meaning. Each tends to identify with the patient discussing his problems or, on the other hand, with the therapist. Thus there is abundant opportunity for a sharing of common varieties of emotional suffering.

Some men integrate with the group rapidly, others more slowly; some take the rôle of leaders, others of followers. The more aggressive persons activate the more timid ones. The weaker men attach themselves to the stronger ones. The timid ones often envy the more exhibitionistic personalities. The sadistic patients tend to attack the submissive ones. At times, there are veiled homosexual flirtations. Often one patient attempts to show up another's weaknesses in order to avoid exposing his own. Inadequate or stereotyped explanations of motivation are challenged. In this process, gradually, the layers of evasion, defense, and rationalization are stripped away piecemeal so as to lay bare the real nature of the reaction. Sooner or later, this progressive uncovering of systems

of psychological defense permits a clearer view of the underlying emotional trends and related anxiety patterns. The patients themselves often spontaneously offer interpretations of basic motivation. Sometimes these are keen and accurate; at other times, egocentrically misguided. These interpretations are sometimes all too vigorous, and are exploited as a means of attack, but the attack by one patient on another is frequently diluted with a touch of humor.

The relationship patterns are multiple and varied. The men give each other emotional support, show strong bonds of loyalty, and at times display sharp competitive tendencies. The prevailing attitude toward the therapist is a dependent one. The multiple inter-personal patterns in the group provide abundant opportunity for displacement and dilution of transference emotion. Hostility toward the therapist is often shunted off to other patients, but is occasionally expressed directly.

The therapist is an active participant, but enjoys a special position. He is imbued with some degree of authority and prestige and personifies the aim and life of the group. The ultimate control of the experience rests with the therapist. He integrates and stabilizes the group. He must balance the dynamic forces, and regulate aggression so as to prevent it from jeopardizing the unity of the group. He catalyzes the release of repressed feeling and channelizes this release toward a more accurate understanding of the patient's problems. He employs the technique of interpretation only when the emotional trends have become clearly crystallized.

The following case histories illustrate the effects of the therapy upon various types of patient.

Patient 1.—This man, aged thirty-two, suffered a combat neurosis after several months of battle experience in Africa. The illness began with a mounting jitteriness. Then, after a period of excessive hardship and danger, during which other men in his company were killed, he became exhausted, wild, uncontrolled, and developed a temporary amnesia.

After discharge from the army, which he bitterly resented, he was still in an over-tense, dazed, irritable, exhausted state. He suffered from headaches, insomnia, and temper outbursts. His fatigue was enormous, so that any job proved too great a strain for him—he quit one after another. Even after changing to civilian clothes, he continued automatically to salute officers as if he were still in the army. He felt that most civilians were hypocritical, and he could not reëstablish

satisfactory social relationships. He was violently embittered against the "brass hats," the war profiteers, and the strikers.

Before going overseas, he had married a woman with three children by a previous marriage. He was now separated from her. She was an alcoholic with pathological impulses and paranoid. She made excessive sexual demands on the patient, who felt that she was draining all of his strength. If he did not give her her way, she threatened suicide. The patient felt intimidated and described his life with her as "an uninterrupted hell." He had a strong desire for a home and, since he had had no family life of his own since the age of fourteen, he became devotedly attached to this woman's children. Ostensibly, he wanted a divorce. Actually, however, he took no effective action toward getting one until he had been under group treatment for some time. His underlying dependent and masochistic attitude blocked him from any decisive movement toward a divorce.

In the group situation, he was at first hesitant, took a back seat, and listened to the others. But he quickly became intensely interested, grew bolder, and began with mounting excitement to express his feelings. He told the story of his breakdown and launched a tirade against the army for discharging him in his present state. He reproached the authorities for putting him on a job instead of rehabilitating him socially first. He attacked civilians for their insincerity and for their picayune grievances against the inconveniences of the war. He spoke of the civilian opportunities he had missed while engaged in the armed services. He dramatized his murderous rage against the strikers in the war plants.

In these discussions he released a tremendous amount of pent-up aggressive tension and step by step restored his sense of self-esteem. He received a great acclaim from the other men and enjoyed it. He got enormous satisfaction from the feeling of kinship with men who understood his experiences. The emotional support that he derived in this way seemed most important. His feeling of self-confidence was greatly strengthened.

He discussed at length his feelings toward his marriage, his fear of his wife—especially his fear of being physically assaulted by her male relatives if he dared to leave her. He was convinced that her sexual demands would drain his last ounce of energy. Finally, through this emotional release and some interpretations, he understood that he had actually avoided getting a divorce because of his guilt, his feeling of unworthiness, and his tendency to cling to a home and a mother no matter how bad it was. He gained the courage then to take legal steps for a divorce, and became able to hold a job.

During this period, his entire physical appearance changed, his health improved, he gained weight, slept well, and lost his fatigue completely. His irritability diminished markedly. This man showed dramatic improvement under group therapy.

Patient 2.—This man, thirty-four, married, no children, had been discharged from the army because of dizziness, fatigue, depression. While in the army, he had resented his superiors and their methods of discipline. He worried about his wife and feared that some injury would come to her—for instance, that she might be struck by an automobile. He had a recurrent thought of choking some one, and feared

to put his hands to his own throat. When released from the army, he felt guilty; his brother had been wounded.

The patient is a talented musician. He is an intelligent, sensitive person, but is overdramatic and boastful, and likes to display himself. He is indecisive, and tends to procrastinate. He resents his wife's nagging and will indulge her just to "shut her up." He resents her demands, but usually complies with them.

Up to the age of sixteen years he had been an obedient child, absorbed in his school work and his musical training. He developed a reputation as a musician and began to earn considerable money. At this age he had his first taste of freedom and became sexually promiscuous. He developed a grandiose notion of his sexual potency. Finally, he married after a nine years' courtship, but only because of the pressure his wife exerted upon him. His own tendency was to delay marriage indefinitely.

This patient responded to the group experience as follows: He seemed to delight in the attention he received when he dramatized the story of his breakdown. He described his anxiety and depression, his fear of choking some one; also, his feeling of belittlement in the army, and his resentment against his superior officers. With a great show of emotion, he discussed his difficulties with his wife and his resentment at his submission to her. Here other patients injected their marital difficulties into the discussion and their resentment of domination by their wives. Neither at home nor in the army did he feel like taking orders, especially from some of the "young kids" who were officers. Further discussion revealed that he wanted to be the "big shot" himself. Other patients echoed similar feelings, which sharply heightened the drama of the discussion. This encouraged the patient to express his hostility more vehemently.

He dramatically elaborated on his fear of crowds, his impulse to push his face through the wall, his impulse to fling something, or to choke some one. He didn't dare to touch his wife's throat. He invited the other men to express their marital problems because he felt that he could help them. When they complied, he instructed them not to expect sympathy from their wives. Rather cynically, he remarked: "You can't get it. She wants it from you." He derived a special pleasure from bragging to the others of his achievements, of his ability to earn big money. He confessed his disillusionment in his wife, especially the fact that she had had several miscarriages. When an operation was considered, he didn't dare encourage her to have it, because, if she died, he would feel guilty.

Considerable group discussion followed this disclosure, centering on his hostility toward his wife and toward all bosses, and involving some questioning as to why he wanted to choke his wife. The patient exhibited some guilt, but this was considerably diluted by the humorous acceptance on the part of the others of his murderous impulse toward his wife. The patient himself appeased his conscience by saying that in spite of everything, he was a "good boy" with his wife. He gives her anything she wants as long as she doesn't nag him.

In later sessions, the patient became more defensive about his own problems. He seemed to prefer to preach to the others about their difficulties. He remarked that self-analysis may be injurious; he became somewhat overbearing and tended to assume the therapist's

rôle with the other patients. This defensive maneuver was interpreted to him, as was his obvious aggression against the therapist. His tendency to cover up his own difficulties by assuming a superior, preaching attitude evoked a more pointed discussion of fears of exposing one's real self and fears of dominating women.

There was some discussion of the ways in which men cover up feelings of sexual inadequacy by boasting, particularly when they are not sure of satisfying their wives sexually. This patient bragged of his sexual prowess, but said he used to be scared of sex and venereal disease. Analogous sexual anxieties were expressed by some of the other men; for example, one man was never able to do anything well with his hands—he felt awkward and powerless in any manual activity. This disability was traced back with much good-humored tolerance to anxieties about masturbation. Another man confessed that, in the company of women, his mind gets paralyzed. He feels powerless to make any kind of approach to women. He has no confidence in his worth as a man. The patient himself was completely unable for a time to use his hands on the piano. Now he is again able to play.

There was some discussion of the importance of satisfying one's wife sexually. Sometimes if the man doubts his success, he tries to indulge her in other ways. There was some further discussion about some men being dependent on wives as they had been on their mothers, and the resentment that such men feel in meeting the demands of bossy wives.

This patient showed partial improvement under group treatment; his anxiety diminished, he was less tense, his fear of choking some one subsided. He can now put his hands to his own throat, but still dislikes tight collars. He has better relations with his wife. He has been working regularly, is earning a high salary, but from time to time has bouts of irritability and moodiness.

Patient 3.—This patient, an unmarried man, aged thirty-four, presented a diffuse array of physical and mental symptoms: on the physical side, dizziness, weakness, diarrhea, palpitation, elevated blood pressure; on the mental side, insomnia, fear of crowds, fear of dirt, and a variety of compulsive symptoms. He showed a strong tendency to blame himself for anything that went wrong.

This man's illness was precipitated after his father's suicide ten years ago.

He became strongly attached to the group and attended each session faithfully. He developed a strong emotional bond with the other men and with the therapist. The group experience provided him with an opportunity to release his repressed hostility toward his father, for whom he had specific death wishes. The group discussion clarified the nature of these death wishes and the overwhelming guilt that the patient felt after his father's suicide. The co-presence of such hostility and the intense dependent strivings toward his father created a difficult conflict for the patient.

This patient responded to group therapy with symptomatic improvement—namely, a lessening of tension and anxiety and a marked diminution of his extreme guilt reactions, but there was no essential change in his character.

Patient 4.—This patient, aged nineteen, unmarried, had been discharged from the navy without honor, after an episode in which he

had become intoxicated and engaged in a homosexual adventure. He reacted with an overwhelming sense of shame, became depressed, and tried suicide. He had a great dread of returning to his family and friends. His shame blocked him from seeking a job.

In the group he was, at first, cautious and inhibited. He adopted a passive rôle, and preserved his secret. Later, he acquired sufficient courage to confess his personal disgrace and discovered that the men in the group accepted him, although they knew of his homosexual episode. His defensiveness decreased, he was less belligerent, he obtained a war job, felt less shamed toward his family and friends, and became engaged to a girl friend. Here, again, while there was no basic change in this man's personality traits, he became symptomatically improved, and achieved a better social and occupational adaptation.

Group therapy can be viewed both as an experience in social reëducation and as a special form of psychotherapy. It is, first of all, a real social experience. The therapist is a more real person than in the individual-therapy setting. The interpersonal relationships in the group approximate experiences in ordinary social life; the relationships are spontaneous and natural, and provide a dynamic basis for a continuous flow of emotional support. Through the mutual attachments formed in the group, certain types of emotional need are directly gratified—for example, the need for acceptance, respect, and protection. In this setting, social reality is a variable entity, personified either by individual members, or the therapist, or the group as a whole. A free opportunity is afforded here for an impact between repressed emotional drives and various forms of social reality, through which the patients may test out the nature of these realities, and also of the repressed tendencies. Guilt reactions of the milder and less fixed type can be effectively modified. Access to unconscious tendencies is variable—at times effective, at other times difficult to sustain and to deal with systematically.

In general, the group method seems to offer a means for therapeutic resolution of some types of social maladaptation and emotional disturbance of relatively recent origin. Within certain limits, it is also a suitable instrument for modifying socially inefficient defense patterns and for the analysis of maladapted character traits—for example, a chronic tendency toward failure, drives for perfection, and a tendency toward emotional isolation. In general, the quality of emotional release that the group situation provides is more adapted to "externalized" patterns of conflict. In addition, the group

method encourages sublimations and reaction formations of a socially useful type.

Generally speaking, group therapy is a more real experience than individual therapy. It is less bound to the irrationalities of the unconscious, and is weighted on the side of allegiance to social reality. It can be a total therapy for milder personality disorders, but is only a partial therapy for more serious conditions. Its therapeutic powers are sharply limited for chronic, rigid personality distortions with deep unconscious roots, particularly those associated with specific symptoms and fixed patterns of secondary exploitation of illness. Its greatest effectiveness seems to be in the area of reintegration of ego patterns, with resulting improvement in social adaptation.

It should be stressed that group therapy is an independent method serving certain special purposes. It is not a substitute for individual psychotherapy, and is not in competition with it. For certain patients it may be usefully combined with individual psychotherapy.

LESSONS FROM MILITARY PSYCHIATRY FOR CIVILIAN PSYCHIATRY *

BRIGADIER GENERAL WILLIAM C. MENNINGER

United States Army

IN presenting the high lights of army psychiatry with the view of discussing their application to the civilian practice of psychiatry, it would seem helpful to review briefly the size and scope of the problem in the army. As a background, one needs to keep in mind the particular social system of the army, with its regimentation, discipline, and dictatorial nature, which caused the thousand and one stresses that confronted the soldier. All else became secondary to his new vocation of learning how to kill and how to avoid being killed.

Between 1941 and 1946, there were over 1,000,000 admissions to the various neuropsychiatric services in army hospitals, in contrast to the 97,577 in World War I. Only 7 per cent of those admitted to hospitals were suffering from psychoses. Between 75 and 80 per cent were cases of psychoneurosis and other personality disorders. The rest were neurological problems, including convulsive disorders.

Not included in the number of patients admitted to army hospitals were the thousands and thousands of cases that were seen in the out-patient clinics of each hospital, in the thirty-six mental-hygiene consultation services, and by the division psychiatrists. In a conservative estimate, at least three men received psychiatric help outside for every one who entered the hospital.

As further background, it is interesting to note that, in 1941, the army thought of psychiatry largely in terms of the disposal of psychotics. It was true that a psychiatrist was included in the personnel of hospitals, but the only preparation made for the care of psychiatric patients was an excess number of locked wards in these hospitals. In that same year, there were only ten directives issued in the whole army

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that had anything to do with psychiatry. Five of these had to do with psychoses and three more had to do with "ineptness or undesirable traits of character." All but two of them were concerned with the disposition of such patients.

With this sketchy picture of the size and kind of the patient load, should go a discussion of the environment in which psychiatric patients were treated and finally of the particularly pertinent civilian applications of our psychiatric experience in the war.

ENVIRONMENT OF THE PSYCHIATRIST'S WORK

An important part of the patient's care in every medical installation depends upon the organizational relationships, personnel, and facilities. Of pertinent interest from military experience are the relations of psychiatry to medicine and surgery, the rôle of the commanding officer, assisting personnel, treatment, psychiatric terminology, and some clinical data.

Psychiatry's Relation to Medicine and Surgery.—By chance, and probably without the advice of a psychiatrist, the original plans called for two major services in all hospitals—medical and surgical. Psychiatry was conceived as a subsection of medicine; the psychiatrist was responsible to the chief of medicine. Neuropsychiatric policies, therefore, were subject to the internist's (medical officer's) approval, change, or veto. This type of organization provided an opportunity to observe the good and bad effects of subjecting so broad a discipline as psychiatry to the administration of a specialist in another field. The psychiatric service was handicapped by such an organization except in those instances in which a medical chief was oriented to it and sympathetic to delegating its control to its own specialty chief.

As the size of the psychiatric problem increased, it became apparent that psychiatry should have the opportunity to function as an independent division. The precedent established in the Surgeon General's Office of three parallel divisions—of medicine, surgery, and neuropsychiatry—was the example that was followed in many echelons of the medical department. The creation of the separate division of psychiatry did not detract from the close relationships and the opportunity for mutual indoctrination by the three services.

There were some suggestions made that would have placed psychiatry in a somewhat isolated situation. Consideration was momentarily given to the establishment of several large hospitals to be devoted entirely to the care and treatment of psychoneurotic patients, and at one time a special neuropsychiatric camp was considered. Fortunately, such ideas were tabled because of the conviction that psychiatry needed and wanted to be intimately and closely related to medicine. The system of having medicine, surgery, and psychiatry associated in all hospitals in the army had some disadvantages and complications. However, a very great advantage was the elbow-to-elbow working that exists in few civilian hospitals. In many instances, the internist made regular rounds on the psychiatric wards, and conversely the psychiatrist on the medical wards.

In civilian medicine, the necessity for state hospitals has contributed to the isolation of psychiatry. Many psychiatric patients cannot be treated in a general hospital unless the equipment and program of that hospital can incorporate reasonably elaborate opportunities for occupational, recreational, and educational therapies. Our immense urban hospitals are confronted with the lack both of adequate space and of facilities which, if only for economic reasons, would be prohibitive for the care of such patients. In the army, however, the psychiatric service was frequently in a position to develop these necessary adjunctive treatment facilities in a general hospital, so that the internist and the surgeon became aware of and educated in the total psychiatric treatment program.

It is difficult to estimate the ultimate value to psychiatry, as well as to medicine in general, of this army experience, in which the staff of one specialty daily lived with and learned to know the staffs of the other specialties. Every medical officer left the army with far more understanding and interest in neuropsychiatry than he had had when he entered. Every psychiatrist was, for better or worse, a missionary and an evangelist for the wider use of psychiatry. An illustration of this point is that the psychiatric service probably held a larger number of consultations than any other specialty. In the army, consultations were easy to request and obtain. This might have been due to scientific laziness, or to refusal to accept full responsibility, or to the traditional policy which

required "clearance" for a patient suspected of having a disorder in any specialized medical field. Whatever the causes, the ultimate benefit to psychiatry was tremendous.

The Commanding Officer.—A condition that widely affected the efficacy of psychiatric practice was the attitude of the commanding officer of the hospital, corresponding in civilian life to the superintendent, clinical director, or manager. The army system of professional consultants gave some of us the unusual opportunity to visit and inspect hundreds of army hospitals, an opportunity afforded very few psychiatrists. One of the most vivid impressions was the influence, for better or worse, of the commanding officer on the standards of medical practice. The hospital was like a mirror in reflecting his capabilities, interests, and lack of interest.

Because psychiatry carries so many prejudices, the psychiatric section was a particularly sensitive barometer of the vision of the commanding officer. Regulations required that he make weekly inspections. One would find, in some instances, an officer who was concerned with the treatment of patients; another would concern himself about the mops' being dried correctly. The first type rarely missed the mops, but the second type never seemed to know that the patients were the reason for the hospital.

Where the commanding officer was a doctor with administrative ability whose interest was sufficiently broad to enable every service to perform at its maximum efficiency, his vision encompassed an orientation toward an understanding of psychiatric practice. In some instances, he had to serve as an arbitrator between services, but in most cases he was able to rely on the professional judgment of his chiefs of services. His principal rôle was that of appreciating the value of and providing the necessities for maximum function.

Ancillary Personnel.—A major development in standards of practice was the widespread utilization of clinical psychologists and psychiatric social workers. Although it is an accepted fact that in the ideal civilian practice of psychiatry, these individuals should be utilized, there are many large civilian psychiatric clinics and hospitals that do not use this team. The army applied this plan throughout and convinced those of us in charge of their essentiality. In the Surgeon General's Office, the psychiatric treatment center, the general

hospital, the consultation service in the basic training camps, and in every correctional installation, these workers effectively coöperated in the practice of a better quality of psychiatry than could have been possible otherwise. Many of the psychiatrists had not had the opportunity to work with such ancillary personnel in their previous experience, but in the army discovered their value.

We gained tremendously from the help of the clinical psychologist, despite the fears and petty jealousies of him that existed in some places. There were a few instances in which the psychologist was more capable than the psychiatrist. There is no question that some psychologists do set themselves up as appearing to practice psychiatry in civilian life, but this is decried and disapproved by their own leaders. There were instances in the army in which lack of appreciation of the psychologist's capabilities led to a misuse of his efforts, but the total experience was a very satisfactory one, with mutual respect and coöperation from all concerned.

The psychiatric social worker, both military and Red Cross, became an indispensable member of the psychiatric staff, carrying out a somewhat modified, though no less important, responsibility than in a civilian psychiatric practice.

Treatment.—Initially, psychiatrists in the army were limited in their functioning to making diagnoses and disposing of patients. By the end of 1943, this practice had been changed, and by the end of 1944, directives had been issued for definite treatment to be provided for psychiatric conditions. An all-out effort was made to develop intensive treatment efforts for psychiatric patients throughout the army.

The situation in the army was ideal for the institution of such a treatment program. Because of its organization, a directive could be sent to every hospital, making treatment mandatory. Uniform instructions on methods and techniques could be issued to every hospital. Patients were seen much earlier in their illness than is ordinarily possible in civilian life. They were of an age group in which the incidence of serious mental illness is probably lower than in any other. Even granting all these favorable factors, the results were a highly gratifying evidence of the effectiveness of psychiatric treatment.

No one was under any illusions that these efforts ever pro-

duced optimum results; there was a shortage of personnel; overseas hospitals lacked facilities and equipment. Yet the fact remains that 60 per cent of combat casualties were salvaged for further duty within fifteen miles of the front. An additional 30 per cent were salvaged for non-combat jobs in overseas areas. In the convalescent hospitals in this country, 25 per cent, or in some hospitals as many as 50 per cent, were salvaged from the 10 per cent who could not be returned to duty overseas, truly a remarkable achievement.

The high recovery rate, not only from neurotic, but also from psychotic reactions was phenomenal. By 1945, seven out of ten psychotic patients were sufficiently recovered to return to their homes, rather than to a veterans hospital.

The army in its necessity developed a system that promptly detected the soldier who was unable to adjust and early referred him to a psychiatrist. This system prevailed from basic training camp to combat.

The net result and lesson from this experience was that intensive, effective treatment could be and was instituted for a large number of psychiatric patients. It would seem that army psychiatry proved without a doubt that even with limited personnel, the treatment job could be done, if the attitude prevailed that this was the chief aim. It served to prove the theory that psychiatric patients, if treated early, have an infinitely better chance to recover. Our experience revealed the relative effectiveness of treatment for even a comparatively short period. The pressure of time, coupled with the shortage of personnel, made it possible to give only abbreviated, intensive therapy in army hospitals and in combat situations. Often such treatment had to be given by a physician with no other than a three-months training course in psychiatry.

Three of the outstanding therapeutic contributions were the improvement of group psychotherapeutic methods, experience with psychotherapy under sedation, and the development of an elaborately organized program of activities for neurotic patients. None of these was essentially new, but each was greatly elaborated and a mass of new experience accumulated.

Group psychotherapy rose to prominence through expediency. It seemed to be the best method for the psychiatrist

to spend some additional time with his patients. Following the adage that "necessity is the mother of invention," it became recognized as having many advantages not possible in individual psychotherapy. Most conspicuous of these was the sharing among the group of problems that the individual had assumed to be unique to himself. With the sharing came the finding of solutions in the contributions of other patient failures or successes. The social forces of group opinion, approval or disapproval, became one of group therapy's major advantages that was most effectively developed in the correction installations. This method of treatment seemed to be more effective in changing attitudes than in actually relieving symptoms, but the two can hardly be separated.

Psychotherapy under sedation was widely utilized, sometimes by very skillful practitioners, sometimes by very blundering, untrained individuals. Special credit should go to Dr. Roy Grinker for early work in this field and for his emphasis on the correct technique and value of this approach instead of its use as a panacea, as it was regarded by some. Many others made significant contributions to the method. The experience gained would suggest that it is an extremely valuable short-cut method and that, if properly used and further developed, it might be one of the chief contributions of military psychiatry to civilian practice, as one type of abbreviated psychotherapy.

The third contribution to improved therapeutic technique was possible chiefly because of the almost inexhaustible resources expended by the army for the treatment of disabled soldiers. In the twelve convalescent hospitals of the army service forces and in a considerable number in the air force, an elaborate system was developed. The individual patient with a neurotic reaction was exposed, in consecutive series, to individual psychotherapy, group psychotherapy, and a battery of educational, occupational, and recreational opportunities, hardly available in even the most ideal civilian psychiatric-treatment center in the country. Money was not spared in providing the equipment of these hospitals; an average of $5,000,000 was spent on each hospital; each of them had an educational faculty of from 50 to 150 instructors; each was staffed with selected psychiatrists whose efforts were augmented by clinical psychologists and psychiatric social

workers. The results represent one of the psychiatric triumphs of the war. From the army's original policy of no treatment for such patients, it is an even greater achievement.

Terminology.—The Neuropsychiatry Consultants Division of the Surgeon General's Office was forced into undertaking a revision of the psychiatric nomenclature. This effort was divided into two related, but separate parts. One was to revise the terms themselves to avoid the pitfalls of such group terms and catch-alls as "psychoneurosis," "constitutional psychopathic personality," "simple adult maladjustment," the use of which had created such very special problems in the army. The help and the suggestions of a considerable number of the leaders in American psychiatry, both in and out of the army, were obtained before its final production after a study that consumed the better part of eighteen months of intensive work. The second effort was to determine on a method of recording and amplifying the diagnosis by a statement (in addition to whatever diagnostic term was used) which would indicate the predisposition, the provocative external environmental stress, and the resultant degree of disability or incapacity.

Our experience brought into bold relief that fact that standard nomenclature currently in use in psychiatry was totally inadequate to meet army needs. Prior to the war, there had never been a situation in which rigid conformity to some standard had been required by such a large group of men who were so widely dispersed and so varied in their function. Many progressive civilian hospitals and clinics had developed their own modifications of the standard nomenclature, which led to varying conceptions and consequently different diagnoses of the same condition. In the army this state of affairs presented both the opportunity and the necessity for an attempt to correct this situation.

A second difficulty in the use of standard psychiatric terminology in the service was its limitation of terms for minor personality disorders. In army experience, 90 per cent of the problems confronting the psychiatrist did not fall in the psychotic group for which the standard psychiatric terminology had been well worked out. The number of clinical entities listed in the standard nomenclature for the psychotic reac-

tions is at least three times that for the non-psychotic reactions. Therefore, although there was little difficulty in finding a reasonably accurate and definite term for the psychoses, there was no suitable diagnosis for many minor adjustment problems. The psychiatrist saw acute combat conditions, which defied any classification under the standard nomenclature. In the training-camp clinics he saw many minor personality disorders, situational reactions, and moderate regressive phenomena for which he could find no label.

Still another objection to the terminology was the difficulty encountered by general-medical officers in their army practice, faced with the constant necessity of using psychiatric terminology. Whether or not the complaint of their inability to understand our diagnostic terms is justified, it is an indication of their interest and need. When they saw a soldier with a functional upset stomach, they did not know whether they should call it "anxiety state," "anxiety neurosis," "psychoneurosis," "conversion hysteria," or perhaps use a symptomatic diagnosis of "gastric neurosis" or "neurasthenia gastrica," or in desperation label it either "no disease" or resort to "gastritis mild." The need for a more complete diagnosis than merely one term was voiced not only by psychiatrists, but also by boards of medical officers who had to decide on the patient's disposition.

Another difficulty concerning nomenclature arose from the army policy of deciding the disposition of a psychiatric patient on the basis of his diagnostic label. Early in the war, when minimal standards were set up for admission to the army, it was assumed that no man would be retained in the army if he fell below these standards, a regulation that was obviously not practicable. These acceptance standards rejected a draftee who presented evidence of having a psychoneurosis of any degree of severity. In psychiatric practice in the army, this standard was, therefore, interpreted to mean that any man given such a diagnosis should be discharged. On the other hand, if in the opinion of the psychiatrist the man could do further duty, then he, the psychiatrist, would scramble around for some other label that would permit him to retain the man in the service. Sometimes psychiatrists, because of pressure put upon them or because of their own

lack of judgment, used some diagnostic term—most often "psychoneurosis"—for the prime purpose of discharging a man from the army.

In the development of a method of recording the diagnosis, it was apparent that merely putting down a specific reaction type like "anxiety reaction" did not enable a medical officer or a layman unfamiliar with this term to judge the patient adequately. In the army, it was important to indicate whether the soldier could function or not. It is well recognized that a neurotic patient with a predisposition, as indicated through previous illnesses, has a much more serious prognosis than the man who has no past history of ill health. Further, it was widely recognized that a man who broke down with minimal stress presented a different problem from the one who became ill only after very severe stress. Consequently, in formulating the diagnosis, the physician was instructed to record the reaction type, and, in addition, to state briefly the degree of the external stress that precipitated the illness as "severe," "moderate," or "minimal." He was to indicate the predisposition as either being "not apparent" or as "mild," "moderate," or "marked." And finally, he was to indicate the degree of incapacity as "none," "minimal," "moderate," or "marked." It was hoped that this plan might have a wider application than merely its use by the psychiatrists; it could serve as a guide for any physician making psychiatric diagnoses, and would give even an intelligent layman a better understanding of the patient's illness.

Clinical Data.—Experience in military psychiatry has undoubtedly contributed some new clinical data to the field of psychiatry. It has done so against the great odds of speed, of lack of personnel, of lack of research opportunities, of having to deal with large groups of patients unexpectedly, and of a long list of prejudices to complicate its functioning.

Some of this data forced psychiatry to accept a revised concept of the term "normal" as applied to effective soldiers. A very extensive investment of effort was made in trying to select men at induction centers. Despite the fact that we rejected 12 per cent of men at this level, our psychiatric casualty rate was about the same as that of the British, who had rejected less than 2 per cent at induction. In comparing these

figures, note should be made that the British had a much better placement system for limited-service men.

We learned that many unstable personalities, under certain circumstances, functioned valiantly and over long periods of time in combat. We saw others who gave no history of predisposition to mental or emotional instability who developed such under minimal stress. We learned that certain induction centers that had rejected the highest percentages of presumed potential psychiatric casualties had nearly as high a number of men subsequently discharged for psychiatric difficulties as did some other induction centers with low rejection rates—sometimes a higher number. Army experience indicates that as yet no very good method has been found whereby to determine a man's threshold of endurance of emotional stress or his ability to utilize supportive influences.

Psychiatric observations led to a renewed appreciation of the importance of stress from social forces as a major factor in the causation of psychiatric casualties. The major adjustments that were required of the average soldier could be measured in their effect in terms of how the same stress affected one individual as compared to others in this group. In evaluating the stress—or, more specifically, the causes of breakdowns—the picture became complicated by the numerous influences that strove to maintain the man's functional integrity. Contributions to disintegration of the personality were the effect of fear, the tremendous importance to the ego of secondary gain in illness, the strain of isolation, physical discomfort and privation, negative influences reflected from the home front, and a host of other difficulties. Factors that aided integration were effective leadership, identification with the group, motivation or conviction as to the importance of the job, the confidence gained from training and belief in the weapons.

The recognition of the effect of these extreme stresses on the personality with inadequate support does not in any way minimize the influence of defects in the structure of the personality or internal stress or both together as causes of psychiatric casualties in the war. The end result can be interpreted only on the basis of the strength of the ego to withstand the combination of external and internal stress, and

no complete understanding of any case could be expected without knowing both in detail. In the army, both because of the lack of qualified psychiatrists and the lack of time, there was much less opportunity to obtain adequate data on the internal stress. On the other hand, the opportunity was present, almost as clearly as in a planned experiment, to see the effect of external stress on an individual.

IMPLICATIONS FOR CIVILIAN PSYCHIATRY

Army psychiatric experience reveals both the possibilities for its greater influence and the challenge of its need. In a sense it turned out to be the handwriting on the wall for some of the future trends in this field.

Administrative Methods.—There are at least four suggestions from army experience that relate to administrative methods in psychiatry: the rôle of the commanding officer (or superintendent or manager), the importance of greater utilization of ancillary workers, the reduction of required "paper work," and the revision of nomenclature.

Observations of commanding officers who were charged with running army hospitals revealed the need of a standard for their selection and a standard of operating procedures for the various sections of the hospital. Because a physician has been a good clinician in a particular field is no basis for giving him the administrative responsibility of a hospital without ample training in administrative work. On the other hand, an administrator without clinical experience is undoubtedly under a great handicap. Unless provision is made for supplementing his lack by consultation with his professional assistants, this handicap will affect every service in the hospital. Failure of the institution to fulfill its mission is assured if its administrator is chosen merely on the basis of length of service or is given the position as a reward for service or as a form of semi-retirement. Psychiatry, above any other specialty, needs the aggressive support and understanding of whoever may be in charge of a hospital of which it is a part. As long as the choice is made on a political or a favoritism basis, with no regard for training and experience, we can never expect our psychiatric hospitals to be effective therapeutic installations.

The use of auxiliary personnel must be greatly augmented.

Faced with the shortage of psychiatrists for several years to come, this is imperative. Not only do clinical psychologists and psychiatric social workers have much to offer in the diagnosis and treatment of mental illness, but we could profit greatly from an increase in psychiatric nurses, and recreational, occupational, and educational therapists. Every major psychiatric institution should take the initiative in developing or expanding training programs for such personnel. It may be significant that there is no recognized or organized university course to train either educational or recreational workers for hospitals, and that neither of these groups have an organization among themselves comparable to that of the occupational therapists.

A major time-consuming function of the military psychiatrist was his paper work, often necessarily accomplished with inadequate secretarial help. It has been facetiously remarked that a psychiatrist could not function without his pen, referring no doubt to the accepted fact that the composing of a psychiatric record calls for many times the effort of the present system of records in any other specialty. It is highly desirable that the psychiatrist reduce the investment of time in his paper work. Provision of adequate secretarial and clerical help is a necessity both for the psychiatrist and for other skilled members of his team. In addition, ways and means must be found of affording him more time with his patients by reducing to the minimum the essentials in his records. Every effort should be made to permit utilization of psychiatrists at this moment of their great scarcity. A more brief examination record could be used by the general practitioner and other specialists who, it is to be hoped, will in the near future include in their records some notes on the psychological state of their patients.

The army's revision of the nomenclature should be regarded merely as a further evolutionary stage in the development of a clear and concise standard method of recording an abbreviated picture of a psychiatric clinical entity. It is to be hoped that there will be many additions and changes through wide consideration and criticism as a result of its use by civilian doctors. There is need for a more systematic and dynamic definition of the psychoses. There is an even

greater need for the delineation of the minor reactions of the average man—the types of psychopathology of everyday life. The difficulties encountered in the proper application of diagnostic terms, more clearly than almost any other experience in army psychiatry, reflect the divergence of opinions and the lack of standardization in psychiatric thinking. To express ourselves more specifically, more concisely, and more understandably should be a number-one challenge to all psychiatrists.

New Attitudes of Army-Civilian Psychiatrists.—Every medical officer who went from private practice into military service, like every other civilian who joined the army, had some major readjustments to make. Some of these were internal and personal. He was uprooted from his home, and his departure for the army carried with it economic handicaps, probably as great or greater than that of any other single group that entered the military service. In an established practice, the doctor is an extreme example of American individualism unless he is a member of a university faculty or of a large clinic. He has practiced medicine the way he wanted to, governed only by his own ideals; he did not have a superior who told him how or when or what to do.

When he entered the army, not only was this changed, but he may have been taken out of the field of his interest and specialty and assigned to a different type of work. In addition, he had to take hikes, drill; he had to learn military courtesy and practice, mapping, courts-martial, supply, and other military subjects. While all of this was happening, he was swamped with patients. The combination of changing policies and new directives, with his huge load of paper work and rapid turnover of patients, gave only minimal opportunity for the satisfaction of seeing people get well.

The psychiatrist had certain unique problems. He had to reorient to making the interest and needs of the group rather than the wishes and needs of an individual his primary aim. This meant that his job might entail the returning of a soldier to a duty assignment that probably would make him worse. If the group needs demanded it and the soldier could give further service, such became the psychiatrist's responsibility.

Furthermore, not until late in the war was he given the

authority to treat. By that time he had been impressed with the mass need and the necessity for abbreviated treatments, and his function was limited to doing the most for the largest number. Specialized problems, particularly the social misfits or very rare syndromes, could not be given much time or effort. He was surprised at the inadequacy of, and resistance to, psychiatric understanding on the part of most medical officers. Possibilities of prevention, through attempting to modify the social stresses and strengthen the ego's capacity to accept these stresses, became part of his responsibility.

After such a varied practice, psychiatrists with military experience will return to civilian life with their previous concept of psychiatric practice markedly modified. There may be less appeal in the job of custodian in a politically managed state hospital. It will be more difficult for them to be content to spend an hour a day with each of six or eight patients. Interest in the application of psychiatric principles to groups and situations in the community will be greater. Many of these men will have a strong preference for the out-patient clinic as against institutional work. In other words, they have seen a vision of the greater area of social need for psychiatric help.

Potential Treatment Modifications.—Probably much of the pessimism about, and the fear of, mental illness, which is so widely held by the public, is related to the comparatively low recovery rate. Certainly in civilian life, it is the exception when a psychiatrist is given the opportunity to treat an individual in the early stages of his maladjustment. In the army, the amazing results of treatment, even though it was far from adequate, carry the most significant implications for civilian psychiatry of any lesson from military psychiatry.

The lesson would seem to be that psychiatry must aim first toward active early treatment; it must, if the demands are heavy, be abbreviated. Continued efforts must be directed toward ways and means of making therapy effective through short cuts. Experience raises the question as to how total must be the insight of a patient regarding his illness. If we see the patient early, it may be more desirable to give immediate corrective suggestions, reinforcement, and

support, and trust to the tendency of nature to regain reinforcement rather than to attempt to expose contributory deep-seated conflictual situations of long standing.

This does not apply to long-standing incapacity, as seen in the chronic neurotic adjustment. Such patients were in a minority in the army, and they will require long-time treatment. It does apply, however, to the great mass of average individuals who are momentarily and periodically thrown off their emotional balance, and who have yet to discover the relief to be obtained from psychiatric treatment. Our experience in the army positively indicates that if psychiatry can provide an abbreviated, intensive therapeutic program for this group, its application and usefulness will be multiplied many fold.

This would suggest that psychiatry has not raised its sight sufficiently high to begin to meet the needs that army experience indicates are present in civilian life. We have taken care of the psychotics after a fashion; we have made a start in out-patient work, but only a start. As yet we have not begun to reach the average man on the street. We must conclude that to date psychiatry has fallen far short of its potential contribution and its service must be tremendously expanded.

In meeting this expanded treatment program, we can profit by the wider use of psychiatrists and ancillary personnel. We can adopt group therapy more widely. It is probable that psychotherapy under sedation has some application in civilian life and has the great advantage of being a short cut. The extensive and often expensive provision for occupational, recreational, and educational therapy in army hospitals showed that initial expense in equipment and staff may save in reducing duration of illness that is costly in prolonged custody. The principle involved could and should set a precedent that, if adopted in, and necessarily adapted to, every psychiatric hospital in the country, could go far toward revolutionizing the rate of recovery from psychiatric illness.

In short, the use of ancillary personnel, short cuts in treatment, the saving of time for the psychiatrist so that he may have contact with more patients, are all very much indicated if we are to begin to expand treatment. If we are

correct as to the great need for psychiatric help and as to the shortage of psychiatrists, then we seriously need to reëvaluate the justification for some of our best psychiatrists' limiting their practice to the same eight or ten patients every day, in many of whom they invest hundreds of hours.

Medical Education.—If psychiatry is to meet the need for its knowledge and therapeutic experience, a literal upheaval in our medical education is necessary. There is no hope that psychiatrists alone will ever be able to solve the problem; furthermore, it would be a mistake to let this occur. Every one of us in the army, in the field of psychiatry, was much impressed by the lack of psychiatric understanding on the part of the average medical officer, although he needed it badly. He did not learn enough psychiatry in his medical-school experience and training to be of tangible help to him in practice. It has been estimated that 50 per cent of all patients of all doctors present no organic pathology. Most of these patients do not need to see a psychiatrist, but they do need scientific psychiatric treatment from whomever they see. The only real solution would appear to lie in better training and education in the field of personality disorders for all physicians, so that they will know the anatomy and physiology of the personality as well as the elements of good psychiatric treatment.[1]

In the army, where we were confronted with an even higher proportion of cases with functional disturbance than is seen in civilian life, we saw some disturbing results of this lack of training and knowledge. Too often patients received a diagnosis only by the exclusion of organic difficulties, after indiscriminate and prolonged hospitalization with frequent laboratory testing and X-rays. Occasionally, there were unnecessary operations. Psychologically ill men were treated with indifference or accused of being "gold bricks" or even of malingering. Not infrequently, they were told that nothing was wrong. Unfortunately, because of the medical officer's own conflicts, the patient might even have been aggressively scolded.

Since army doctors were civilians in uniform, this must represent the usual civilian practice also. Our army expe-

[1] See "Neuropsychiatry," by W. C. Menninger. *Journal of the American Medical Association*, Vol. 125, pp. 1103–1105, August 19, 1944.

rience leaves no question as to the value of making psychiatry a basic medical subject to be taught not only as a specialty, but as an intrinsic part of every course in medicine and surgery and their sub-specialties.[1] There is, of course, a dire need for more specialists—a need that has been estimated to be in the neighborhood of 10,000[2] as compared with the present number of 3,500. However, the universality of emotions, of feelings, and their effects on the human body make it imperative that every individual practicing medicine be as well grounded in the anatomy, physiology, and pathology of the psyche as he is in that of the soma.

Graduate Training Needs.—But even if all physicians were oriented to and capable of handling the minor emotional needs of their patients, we should still need a great expansion of personnel in the specialty of psychiatry. One of the amazing discoveries in the army was the fact that we could give a selected young physician a relatively short intensive course and turn out a reasonably effective worker. It was essential that he recognize his limitations, that he be given the support and guidance of more experienced men on his assignment, and that he have the stimulus to continue to study and learn in order to be progressively more effective.

A thousand medical officers who had never had any experience in psychiatry were given such training, and it is estimated that 50 per cent or even more of this number will wish to continue in the field. This represents a harvest of more potential psychiatrists than all of our medical schools combined have produced in ten years. At the moment, we are faced with the dilemma of far from sufficient civilian opportunities for formal graduate training for this group returning from the service. Those of us in responsible teaching positions in psychiatry will have to rise promptly to this challenge, and it is to be hoped that we can do it.

Professional Relationships.—The working in close harmony of the internist, the surgeon, and the psychiatrist proved to be a stimulating experience to those concerned. Civilian

[1] See "Perspectives of Psychiatry, Committee on Medicine and the Changing Order," by W. C. Menninger. *Annals of Internal Medicine*, Vol. 22, pp. 170–88, February, 1945.

[2] See "Needed: 10,000 Psychiatrists," by Thomas A. C. Rennie. MENTAL HYGIENE, Vol. 29, pp. 644–49, October, 1945.

psychiatry must plan to continue the close professional relationship of doctors of many special interests, if we are to reach a stage in medical practice where each doctor will have an adequate grasp of the psychiatric principles that he needs. This can happen only where there is sufficient intimate, regular contact between psychiatry and these other fields of medicine. This will require our more active participation in medical groups outside our own special field. It will demand that more of us present useful and helpful and easily understood psychiatric studies to these groups. It suggests the desirability of the psychiatrist's expansion of interest to include an orientation in current medical and surgical practices and problems.

CONCLUSION

These are only the high lights of the more important findings that military psychiatry can contribute to civilian psychiatry. They show that psychiatry is undoubtedly only on the doorstep of its potential usefulness. Its principles must be more widely known and practiced by every physician. This branch of medicine must come much further out of its shell of isolationism, improve its methods, greatly expand its treatment abilities and facilities. It must become more articulate, and this will require the clarification of its concepts, and, most of all, of its nomenclature. Psychiatry must foster a public-education campaign similar to those against cancer and tuberculosis if the salvage of man power and the prevention of suffering are to be undertaken seriously. It must overcome its self-destructive trends by actively participating in and becoming an intrinsic part of the daily practice of all medicine. Whether it accomplishes all of these aims depends almost entirely on those of us now in psychiatry, our vision of its possibilities, and our abilities to make these plausible and accessible to all those who want and need them.

HIGH LIGHTS ON THE PSYCHOLOGY OF INFANCY

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IN order to understand the psychology of infancy, we must first recognize that there is a close relationship between a baby's physiologic activities—breathing, eating, sleeping, eliminating—and his psychologic reactions. No infant can be emotionally secure unless psychic as well as physical needs are met.

While the fundamental needs of the baby remain the same all through his life, the successive stages of his development vary so greatly that they require different ways of handling, in order to satisfy those needs.

For this reason, doctors, nurses, and parents must not only know more about these basic needs of young humans—they must also have clearly in mind the significant steps of early development. Only with this background can we plan our care of a child so that physiologic activities have a chance to develop wholesomely, thus softening the psychologic difficulties that all children have to face in our complex civilized world.

Every baby, from the moment he comes into the world, is influenced by certain basic needs or drives which are easily recognized by any one who observes young infants over a long period of time. The most evident, perhaps, are (1) the need for physical safety, which includes protection from hunger, cold, wetness, and other dangers that might threaten the life of a young baby; (2) the deep need for warm affection, which broadens out later into the desire to be an approved member of his own particular family group—the "belongingness" spoken of by Lawrence Frank; and (3) the need to grow and develop according to his own inherent pattern and rhythms. This last is the device that safeguards individuality, produces artist, mechanic, or statesman, and

makes each baby different from every other baby, as all parents know.

These needs, so important to a baby, persist under the surface of a child's personality and influence his conduct and happiness from the cradle to the grave. Their great importance to us lies in knowing that when they are unduly thwarted, psychologic difficulties, which we call behavior problems, occur. When they are fulfilled, stable personalities are fostered.

The road to this fulfillment is not smooth. Children, even babies, must learn to conform to the world about them, and our adult world is not built with basic human satisfactions in mind. The problem is one of modifying our demands on a child and easing his daily routines, so that we parallel within reason the kind of life that a growing child is meant to have.

Babies grow and change in an orderly way, according to the sequence of the growth plan, as ordained by nature from the beginning of time. Each stage of development brings new accomplishments, both physical and mental, and only by knowing these steps can basic needs be met all along the line.

The baby, for instance, who at two months is satisfied with breast milk, at fifteen months has teeth for chewing and fingers that can hold a spoon. He needs different food and he needs utensils to work with, if he is to be happy. The child who is content to lie placidly on his back in his play pen at five months needs toys and the wide open spaces at eighteen months.

The early steps of development can be grouped into four general periods: (1) the fetal period; (2) the neonatal or newborn period; (3) the period between the neonatal and fifteen months of age; and (4) the period from fifteen months to two years.

1. The fetal period.—In the months before birth, the unborn baby attains a security never approached in later life. Safe in the warm, moist, dark, rhythmic cradle of the uterus, he does not need to exert any effort to survive. He may be somewhat disturbed by outside or inside stimuli, but these are insignificant compared with the discomforts he will meet in later life. Under normal conditions, there-

fore, we may assume that psychologic difficulties do not exist at this stage of growth.

This being so, can we do anything to meet the needs of the unborn baby during this period of his growth? The answer is, a good deal.

Obviously, good maternal care and an adequate diet for the mother during pregnancy will set the scene for better physical development. And to-day this is coming to be accepted as a routine part of preparation for the birth of a child.

But we are only just beginning to try to orient the mother psychologically toward the future care of her baby. This is the golden age at which to interest prospective mothers and fathers in the nature of young children and the unfolding miracle of growth. It is an ideal time, too, to teach the expectant mother the advisability of breast feeding from a psychologic as well as a physiologic standpoint.

2. The neonatal or newborn period.—This period has received far too little attention, although it is in many ways the most critical time of a baby's life. Psychologically, it should be considered of great significance, partly because it comes first and so sets the scene for future emotional patterns and habits; and partly because it follows immediately after a startling upset in the child's surroundings.

A baby undergoes considerable violence in the birth process. Forcibly pushed and hauled from his complete security into a dry, cold, brightly lighted world, he must immediately take charge of his most vital activities. He must breathe, eat, sleep, and eliminate on his own, if he is to survive.

Fortunately, nature has arranged it so that the newborn baby works on an automatic basis, which helps to protect him through this dangerous period. As a further protection, he is equipped with a loud, raucous cry which he turns on automatically if he is hungry, cold, wet, frightened, if he has difficulty in breathing, or if he senses that he is alone in a cold world.

Obviously, good psychologic care during this period would suggest that we do everything in our power to restore to the baby some semblance of the confidence so rudely torn away by his birth. During this period of new responsibility,

it would be good common sense to support his crude attempts to get started in the world outside by paying attention to his warning cry and satisfying his basic needs.

On the physical side, this would mean adjusting our feeding schedule to his hunger cry, changing diapers promptly at his call, seeing to it that bedding and temperature surroundings are satisfying, and, most of all, attending to his obvious need for fondling. This means picking him up when he cries and giving him rhythmic motion such as rocking and lullabies. For at this moment we are dealing with a frightened, primitive little creature, who is undergoing radical changes in his environment and who is not capable of voluntary activity. His only way of showing his need is to cry. This situation calls for the gentlest and most understanding sort of care if he is to emerge from the newly born stage with any degree of confidence at all.

And it will not spoil him. At this age, he does not cry because he is bad. He cries because he needs something. Our job is to find out what that something is. This kind of treatment, far from spoiling him, will set him off on the right foot in his adjustment to the household.

The best background for mental health is to establish in a child's mind, at the earliest possible age, the unfailing affection of his parents. To this end, endearing words, fondling, lullabies, and rocking should be a part of the baby's life from the first.

Later on, he will sense this affection in countless ways that cannot be enumerated ahead of time, but that depend on the parents' real regard for, and acceptance of, their child. This bond of affection becomes doubly important when, later on, disciplinary measures become a part of the rearing of a normal child.

Every mother has to teach her young child, for instance, the meaning of danger. The gas stove, the open window, the oncoming automobile are potential perils; to learn to avoid them may require discipline. The child will learn more easily if he trusts his teacher. The art of successful parenthood may depend on the ability to discipline a child and still make him feel his parents' unchanging love.

3. Newborn to fifteen months of age.—This period starts

at about eight weeks, when the baby's brain begins to take over control and voluntary activity gets under way. It lasts until he can stand and walk, at about fifteen months.

This is the baby's crude production stage, a period of very rapid growth, of adjusting to routines for eating and sleeping, of developing some efficiency with arm and hand, of beginning to master bowel and bladder control, of learning to laugh and reach out socially to family and friends—a delightful stage and one that is universally admired.

But it is also the stage wherein good psychologic care most often comes a cropper. For modern ways with babies have not been set up to synchronize with a child's own abilities in the matter of eating and sleeping or of bowel and bladder control.

Eating: Good psychologic feeding care would mean individualizing each baby, by finding the timing for meals that best suits his needs. Many babies seem to have a three-hour feeding rhythm and will scream for an hour when put on a four-hour schedule. Insisting on a feeding routine that does not fit is asking for trouble, because it ignores a basic need.

Good feeding care would also mean allowing the baby to develop an appetite instead of forcing food on him, giving him a chance to feed himself as soon as he is able, and respecting his preferences in diet. If he doesn't like spinach, why not try squash?

Sleeping: A sound psychologic approach to sleep habits would be to realize that sleep need never be taught to young babies. They spend most of their time asleep. As they grow, and as successive abilities crop out—such as smiling, talking, using the hands—there is a purpose in being awake and sleep becomes of value as a freshener between thrills of experience.

To get the baby to sleep, then, is a matter of providing adequate sleeping opportunities and the sort of daily regimen that gives him a chance to get wholesomely tired. Sleep never should be a disciplinary agent. It should be enjoyed as one of life's greatest comforts. To put Johnnie to bed to punish him only makes him resent the process and never promotes good sleep habits.

Bowel control: Much misinformation about this subject

has led to premature attempts at bowel training and a good deal of trouble for mother and child. True collaboration with development would withhold such training until the baby is able to sit up alone, can understand something of what is required of him, and has settled down into a rhythm that makes it easy for his mother to know exactly when his daily bowel movement will naturally take place.

This would mean waiting until he is from six to eight months old. Urinary control, which is a much more complicated process for the baby to comprehend, should not be attempted until he is old enough to run about the house.

Neuromuscular development: During the first fifteen months, the development of large muscles makes its most rapid progress. The baby learns to sit up, to crawl, to stand, to walk, to handle his rattle, his cup, his spoon, to play actively with toys and sometimes to feed himself. He must have enough freedom to practice and work at these truly difficult jobs, if his muscular needs are to be met and psychologic storms are to be avoided.

Parents who take time to study the fascinating sequence of growth, and who are proud of the baby's progress, give him a support that nothing else can equal. There is practical value, from the mental-health standpoint, in knowing the type of toy that is useful at each stage of growth, and in assisting the baby by introducing the play pen and other equipment when he is ready to use it. There is even more value in making him feel that his efforts to grow up are really appreciated by his family.

4. Fifteen months to two years.—The high lights of development in this active period are both the baby's ability to get about the house and the improvement in coördination of fine muscles that leads to ceaseless hand and finger exploration. He is literally compelled by the forces within him to push out toward his environment. Unfortunately, this gives rise to trouble as well as satisfaction, for he begins to interfere with his parents' household arrangements in a big way. Mothers call this the "no-no" period, because of the constant need to clamp down on prying fingers.

Although this is the time when the deep need to touch and handle should be met, in reality it is the time when parents too often begin with gusto to try to prevent growth

and to make their children fit the standards of a complicated household. This training is usually given in a conscientious spirit. But without adequate understanding of a child's needs, many people expect adult behavior before a child is ready for it.

Instead of clamping down, it would be more to the purpose to get all the information available about appropriate toys and opportunities for safe and constructive play. Such information is available at any neighborhood nursery school and will give a mother practical help.

Mental health, then, in infancy, is promoted when doctors, parents, and nurses learn what is now known about the basic needs and normal activities of babies, and apply methods of daily care that will synchronize more nearly with the realities of growth and so lessen the childhood frustrations that are all too plentiful in our civilized world.

YOUTH IN SEARCH OF A STANDARD

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DURING periods of great social unrest or upheaval, the standards of value that men have set up as guideposts to mark the path to desirable social living are subject to great stress, to reëvaluation, and often to a complete upset. Many long-accepted criteria of the good life are found wanting, for they no longer meet the need of the day.

These standards that men live by—the means by which we distinguish between the desirable and the undesirable, the good and the bad, in both social and personal living—are things of the mind. They are ideas and ideals that have their reality only in the minds of men. As Americans, we have always prided ourselves upon being a "practical" people who have seldom bothered about ideas of value. We have been willing to fight international wars, to make unbelievable sacrifices, and to die for an abstract idea; we have, however, always considered it a sign of weakness to talk about our ideals or even to take five minutes from our otherwise useless activities in order to evaluate the very standards we are so ready to defend. Superficially, we have accepted as the highest of desirable goals the blind worship of size and number. We have considered it sufficient to have increasingly bigger material things in ever greater numbers, to produce more gadgets and toys, and to do better the things that often never should have been done at all.

To-day, however, because America is passing through a period of transition, many of our older ideas of value are no longer acceptable. The younger generation, just starting out to make its own way in the social world, will need to take thought of its ultimate goals and plot a path to follow if we are not again to end in an emotional and spiritual blind alley. If free America will not take the time to chart its own course of action—a course that is the result of concerted

and thoughtful effort by all—then some one else, probably with a selfish motive, will do it for us.

A large share of the unrest found among our adolescent and pre-adolescent youth has its origin in this loss of a basic standard of behavior. The criteria of what is desirable and what is undesirable in behavior and aspiration have undergone change even during a youngster's short lifetime. The facts that our young people were taught in the schools, the ideals that were held up to them by the home and the church, are at variance with those that they see accepted and practiced by the very people who only a short time ago went to great lengths to teach them otherwise.

We, as adults, have in all finality told the younger generation of the value of education and training, and yet they see the untrained and uneducated receive salaries far above those accorded mature and trained educators. Young people have been told that thrift is a sure path to financial independence, and yet they have seen the savings of a lifetime lost in an hour through no fault of the depositor. They have been taught that living a moral life will bring the highest rewards, and yet daily they see the entire country neglect the work of its scientists and educators in order to follow with avidity newspaper reports of the latest scandals and the open immorality of publicity-seekers. The inconsistencies that the youth of to-day sees about him confuse him to such a degree that he seriously doubts the right of his elders to establish standards of value for him.

Even as periods of stress reveal the weaknesses and patchwork in the social structure, so also they give rise to temporary needs which, if confused with desirable and permanent goals, may lead society into unknown and unpleasant bypaths. One of the dangers of our modern society is that many of the techniques that we adopt as means of solving immediate and temporary problems tend to become self-perpetuating; so that in point of time a need first gives rise to a solution, and then this method of solving a temporary problem, once it has become an accepted standard of behavior, will be perpetuated even in the absence of the need for which it was originally instituted.

For example, both in the home and in industry, children to-day are being exploited by adults because the work that the child is able to do has a monetary value during a period of labor shortage. Even under the supervision of school authorities, waste-paper drives may become scavenger hunts rather than participation in activities that are within the child's range of abilities and designed to give him the much-needed feeling of group activity, of being able to help the social group with which he has identified himself.

Because these temporary measures, such as waiving minimum-age requirements for work or minimum standards of training for teachers, tend to become accepted by society as a matter of course, it may take society several generations to *re*gain in child-labor legislation and public attitude the advances that had been made through the untiring efforts of many socially minded individuals.

Because of their own insecure status in the social order, even institutions supposedly interested in the guidance of youth have been only too ready to approve the needs of the moment and, in their shortsightedness, to subscribe to the popular moods of the day. All too often they have become so occupied with fulfilling legitimate, but temporary functions that they have lost sight of their primary long-range goal—the all-around welfare of youth.

Not only are the standards of what is socially acceptable inconsistent and changing, but to add to his confusion, the child of the present generation is asked to assume adult responsibilities, on the one hand, and on the other, is forced into conformity with increasingly rigid rules. Because the security of his home has been disrupted—either by the actual absence of one of the members or by a virtual absence resulting from preoccupation with work or from additional social responsibilities associated with the influx of unaccustomed financial returns—the youngster of to-day tends to lose his childhood sense of security in the home and the family before he has matured to the point at which his self-confidence and his adult self-sufficiency enable him to live securely in an adult social world. He is thus forced into a broad social milieu and has his behavior judged by adult standards with-

out having that inner sense of belongingness without which he must forever remain a spiritual outsider to the world in which he finds himself.

During normal and more stable times, the transition of the child from one stage of development to another, from babyhood to adult responsibilities, is a gradual and natural process. Social growth is a step-by-step development. Children readily follow a positive suggestion; a single example of behavior by a member of a group they are seeking to imitate is a more powerful guide of action than a hundred negative prohibitions or legal restrictions. A child, by the very nature of group living, tends to set his standards of behavior and values according to those of the group immediately above the point at which he finds himself.

Thus, for example, the kindergarten child knows what is beyond the turn of the road; he knows what he wants to do and to be next. He sees before him the first-grade child, and he sets his goals accordingly. By the time the school year rolls past, he is ready for the first-grade work and behavior standards because he has observed first-grade children, and, as far as he was able, has imitated their conduct. The sixth-grader, similarly, aspires to act, dress, talk, and think like the junior-high student. The junior-high youngster, in his turn, takes his pattern of behavior from the grade above him; for him imitation of senior-high-school behavior becomes the absolute necessity, even as the senior-high-school pupil apes the college youth or the independent young adult. Young people just on the threshold of adult responsibilities likewise take their ideas and standards of value and conduct from the group before them. The son aspires to be like his father in his basic pattern of living at every age. Even as youth looks to maturity for its pattern of life, so young adulthood looks to old age for its guide.

Any interruption of this step-by-step progression is fraught with definite dangers; for if any one section is excluded from this procession, the group just below the break will suddenly find itself without a path to follow. They will be temporarily bewildered; and since the processes of emotional and spiritual growth are continuous and *cannot wait,* they will be forced to blaze new paths. These new paths, because they are the

product of the need of the moment alone, often tend not only to frustrate progress toward the real goals of the group, but also to disrupt the entire social pattern.

This regular procession has, of course, been disturbed at the present time because a large proportion of boys in the late adolescent stage have been removed from the civilian social structure, with the result that they can no longer serve as standards of behavior for the boys immediately younger. Because of this break, the beginning high-school youngster can now no longer follow his older brother, cousin, or friend, adopting his activities and ideals as guides. Once the boy approaches the lower age limit of army induction, the break is clean and abrupt. The change from a seventeen-year-old schoolboy living at home with his parents to the eighteen-year-old soldier living under army regulations is very great, and the standards of behavior acceptable have little in common. For a boy of sixteen to idealize an eighteen-year-old friend, and adjust and adapt his behavior according to what he sees this older boy do, is one thing; for him to accept the impersonal standards of behavior of a mature army group is something quite different.

The break in behavior for the sixteen-to-seventeen-year-old is definite and abrupt; but at least there remains a definite goal that he can see and adopt, no matter how inadequate this goal may eventually prove. The younger adolescent, the fourteen-to-fifteen-year-old, however, is too far removed from the army to be able to identify himself with it; and, being unable to see the goal of peace-time living beyond the war, he often finds himself without a recognized goal of any kind.

This same disruption of standards of behavior affects the adolescent girl, though in somewhat indirect manner. Now, as formerly, the junior or senior high-school girl sets her pace and her standards of behavior in accordance with what is acceptable to the boy she wants to impress. Formerly this boy was an individual who belonged in a familiar social group and setting. There were parents and brothers and sisters involved, and the standard of behavior was a very personal one. Now this standard has tended to become impersonalized because a large number of the older adolescent boys have been inducted into the armed services, and the resulting

behavior is not at all of the same type as that which is called forth when an adolescent girl tries to make a favorable impression upon a boy who lives in the next block, whose parents and entire family background are known to her and her family. The girl still adapts her behavior to the standards set by this very same boy; but now, in her eyes at least, he has become identified with a larger and more impersonal group—the armed services.

The problem of standards of behavior and conduct among adolescents is further complicated by a change in the relationship between children and parents. In the past, the child found it easy and natural to respect and obey his parents because they were obviously justified in demanding respect: the parent could teach the child all the arts and skills that he would need to know in order to live in a simple society. Because of his greater skill, strength, and experience, the father could do all that the son would be called upon to do; and, for the time being at least, he could do it better. It was, therefore, easy for the boy to respect and obey his father.

The daughter, too, once found it natural to respect her mother because the mother was her sole teacher and was the adult who could teach her all of the household skills; furthermore, as in the case of the boy, the parent, because of greater age and experience, could do the necessary work better than the child. This relationship of dependence and obedience usually continued until well beyond the advent of the third generation because the young mother found it easy and natural to respect and obey a parent who was her only source of invaluable aid in child-rearing.

As our social order has become increasingly complex, however, the parent has been forced to share the training of his children with many outside agencies, such as the school, the church, and innumerable special organizations. The inevitable result has been that he has been forced also to share the respect and, with this, the obedience of his children.

Particularly at the present time, the traditional relationship between parents and offspring based solely upon respect and obedience is an impossibility. A son who, after only a few years in school, has developed skills and knowledges beyond those of his parents finds it difficult to respect them

on the same basis as was natural to our great-grandparents. During the current labor shortage, this aspect of the problem has become particularly acute, for a child who is able to quit school at an early age and immediately secure a salary in the labor market equivalent, if not superior, to the earning power that his father has developed over a long period of years will not look upon his parent as the final authority regarding personal and social behavior. To stress the obvious fact that these are unusual times that will not last will make little impression on the boy because youth lacks the perspective to view the remote future except in terms of the immediate present.

Not only have the current unusual labor market and the increased part played by agencies outside the home in the training of children upset the traditional relationship between parents and children, but the situation has been further complicated by a lack of perspective probably unavoidable in any society that is devoting its efforts to war. The wartime emphasis upon youth and the virtues of adolescent abilities, the stress upon purely physiological and physical functioning, has given our young people an exaggerated idea of their own value. Stress upon army standards of physical fitness has given them the impression that unless an individual possesses all of the physical stamina and reckless daring of a frontiersman he is practically useless. Since, according to this *single* criterion, the young inexperienced adolescent can easily excel the more highly trained and experienced mature man, the youngster tends to assume that he possesses a general all-around superiority.

The adolescent's lack of respect for experience and authority, prevalent at the present time, is encouraged by the fact that the current unnatural value placed upon youth and the adolescent virtues has affected the standards of the parents no less than those of their children. Because of society's emphasis upon the desirability of adolescent behavior, parents have often attempted to guide their own conduct by false and even impossible standards. In their dress, their choice of recreation, their standards of value, they have followed the lead of their adolescent children. They have attempted to compete with adolescents in fields where youth,

childish enthusiasm, and recklessness are at a premium, and where the child has every advantage; and they have neglected the activities in which training, experience, and maturity appear at their true value. The parent who competes with his child in adolescent activities makes himself ridiculous in the eyes of his children. The younger generation finds it difficult to respect—or to obey—a parent in whose conduct and standards of value they see a mere imitation of themselves. Youth wishes to grow and to mature into adulthood. If adolescents look ahead and see that the standard of conduct they are expected to aspire to is merely an imitation of their own present behavior, it is little wonder that they are confused.

In modern society the unique contribution of the family is to provide physical care and to give the child that basic sense of security which is the indispensable foundation for all healthy maturity—and this is a responsibility that *can be assumed by no other social agency.* Parents must realize their indispensability in this area and, secure in this knowledge, free themselves and their children from the restrictive traditional concept of the parent-child relationship. Unhampered by the restraints of an artificial and enforced subservience, both parents and children will be able to advance to a more satisfying and productive new relationship with each other. Since the present-day parent can no longer demand nor receive the same type of loyalty from his children that he once was expected to extend to *his* parent as a matter of course, he must teach the new generation loyalty to a code higher than the individual parent. Since blind obedience to parental demands cannot serve as an adequate guide to behavior in a modern world, youth must be taught obedience not to parents, not to the police, but to *a way of life,* to a philosophy of social coöperation on a large scale. In place of respect for individuals, inspired only by fear, youth must be taught to have respect for individual integrity and for personality in a social setting. Parents in a modern world must thus become co-respectors of ideals held in common with their children, rather than tyrants demanding servile obedience and blind, one-sided respect.

Instead of looking at each other, both parents and children

need to raise their eyes to a common and higher goal. The child needs not so much to look at the parent as to look at the goals this parent is trying to reach. The paths that the parents have taken thus become a means toward social and emotional maturity, rather than an end in themselves. Youth aspires toward maturity. At times they can see only the goal immediately above them, and, in any event, they have no choice but to follow and to imitate those who have gone before. They must also be led to realize, however, that the standards suitable for each age level are but markers along the way, and that youth and adults have a common ultimate goal—social coöperation and maturity.

MERIT AND MEN *

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"IN our country," said the visiting G. I. to the British Tommy, "there are no dukes and earls, no kings and queens! A guy in the U.S. travels on his own merits. You see, we're a democracy!"

A guy in the U.S. travels on his own merits!

Like, for example, "the college quota system," "No Negroes wanted here!" "Gentiles, only!" "Protestants preferred!"

Yes, to be sure, "a guy in the U.S. travels on his own merits!"

Is this something new? No.

Pathological? Of course! We Americans are still sick.

America has much sickness—physical, mental, economic, and certainly social. Worthy of special attention is one aspect of our social psychopathology—ethical ambivalence. Of the many instances of such ambivalence, let us consider a particularly glaring contradiction: our readiness to give lip service to the concept that a man stands or falls on his own merits and the ease with which we betray that concept in everyday life.

My presentation will be brief because there is not much that needs to be said. *What is needed is action!*

We have not far to go in our search for reasons for the discrepancy between our professed democratic faith and our daily practice. The bitter truth happens to be that much of our ethical training has been very much in vain.

Dimes and dollars and highly treacherous, false social values carry infinitely more weight with most of us Americans than do the profound and deep truths contained in our Declaration of Independence and in our Constitution. We psychiatrists have a heavy responsibility in this matter.

* Presented at the Thirty-sixth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 1, 1945.

We know that prejudices and discriminatory practices derive from sociological rather than biological sources. We know of the heavy tribute that the victims of such undemocratic aggressions pay. And we also know what these undemocratic attitudes do to the personalities of the aggressors, themselves!

From almost our very cradles, most of us have been schooled in hypocrisy by life itself. As children, we experienced disturbing realizations that what "they" seemed to talk about in church and in Sunday school was not what "they" seemed to act out during the remaining six days of the week. And we found that somehow the inspiring ideas often heard in our civics classes at school were at marked variance with what we heard in our homes and in our neighborhoods.

Our parents protested our lies, and yet almost daily we heard them lying. And if it was not always to us, it was to their friends, their neighbors, and even to themselves!

Soon we found ourselves qualifying our acceptance of the soul-stirring, ethical concepts of religion and the deeply moving principles of democratic faith. We accepted, all right, but with certain modifying provisos and exceptions: "All men are created equal!" *("But we've got to be practical; we are living in a world of reality!")* "Judge and accept a man on his own merits, his own worth!" *("Yes, I would like to, and if it were up to me, I would—but, you see, the people I work with, my associates—I don't want to offend them!")*

There is no need to talk of "projections," "rationalizations," "logic-tight compartments," or other mental mechanisms. Let us talk rather in plain English: *The way to practice democracy is to practice it!* But that means, for many of us, a resurgence of integrity, a willingness to accept some personal and social discomfort, a replenishing of our fund of information, a deep revision of some of our attitudes, and perhaps most of all, a resolution to act courageously upon our knowledge!

What is a prejudice? By its very definition, it stands revealed as an opinion not based upon reality. It is a prejudgment, a conclusion formed without careful examination of the facts.

And we all have our prejudices. They may be mild and socially meaningless, such as prejudices against eating snails or salami, or marrying blondes or brunettes. They may be serious and socially harmful, such as prejudices against people because of their color, race, creed, or ancestry.

Consider these more serious prejudices. If the story stopped with the prejudice alone, it would not be such a tragic affair. So long as prejudices are not implemented, there are no serious social consequences. But the unfortunate thing about prejudice is that it rarely stands still. From prejudice comes discrimination. And from discrimination, in times of serious social tensions, comes outright persecution.

In the army we realized full well how prejudice might undermine final victory. We told our troops: "The man who spreads rumors, particularly race rumors, about any group—racial, religious, or national, is doing Hitler's or Tojo's work. . . . Discrimination on the basis of race, or color [is] fatal to military efficiency."[1] This theme was presented over and over again through various media such as films, discussion groups, lectures, and army newspapers.[2]

And on the home front there was the same problem. Negroes, Mexicans, foreign-born citizens, friendly aliens, Jews, and other minority groups found it difficult to obtain employment—even though there was the constant cry for more and more workers!

Less than six months before Pearl Harbor, it was apparent that our "defense industries" were not fully utilizing our available man power. On June 25, 1941, President Roosevelt had to issue his famous Executive Order 8802, declaring that "there shall be no discrimination in the employment of workers in defense industries or Government because of race, creed, color, or national origin."

This reaffirmation of the basic policy of the United States was a significant step forward. Yet it was met with considerable misgiving and protest on the part of many: "You can't mix Niggers and whites." "It's un-American." "It's

[1] A.S.F. Manual M5, October, 1944.

[2] See "Morale Aspects of Military Mental Hygiene" *(Diseases of the Nervous System,* Vol. 4, pp. 197–201, July, 1943) and "Psychological Training and Orientation of Soldiers" (MENTAL HYGIENE, Vol. 28, pp. 537–54, October, 1944) both by Julius Schreiber.

unconstitutional." "It will result in strikes and walk-outs and violence."

These fears and cries were echoed by many others who believed that the administration was "forcing legislation contrary to *mores*" upon the people of the country. Yet, in spite of considerable obstruction thrown in its way, the Fair Employment Practices Committee, in its successful handling of thousands of cases, gave the lie to these false cries of alarm. White and Negro, Jew and Gentile, native and foreign-born, members of minority groups and members of majority groups *did* work together harmoniously and *did* produce the weapons of war. With a few shameful exceptions, there were no walk-outs, strikes, or instances of violence due to the abolition of unfair employment practices.[1]

There are some who claim that unfair discrimination in employment does not really affect many people and is limited only to certain sections of the country. This mistaken belief cannot stand up when measured by the facts.

In a report to the second session of the 78th Congress (Report No. 1109) Senator Chavez states: "Contrary to the general impression, unfair discrimination in employment is not the exclusive problem of certain regions of the country. . . . There is scarcely any important industrial area of the United States where there is not some form of discrimination sufficient to prevent the full utilization of man power and the free flow of goods important to the national economy."

And from the executive office of the President comes the information that discrimination in employment because of race comprised 81 per cent of the complaints. Practically all of these involved Negroes. Another 9 per cent of the complaints were based upon charges of discrimination because of religion, most of which involved Jews. Another 6 per cent of the complaints received were for discrimination because of national origin.

[1] See Malcolm Ross in his testimony, as Chairman of the Committee on Fair Employment Practices, before the Subcommittee of the Senate Committee on Education and Labor, March 14, 1945. See also *Problems of Economic Discrimination Facing Minority Group Workers in the Immediate Post-war Period* (report of the Division of Review and Analysis, F.E.P.C., August 22, 1945); *Brothers Under the Skin*, by Carey McWilliams (Boston: Little, Brown and Company, 1943); and *The Negro and the War*, by Earl Brown and George Leighton (New York: Public Affairs Committee, 1943).

There is no question about it, prejudice and discrimination have interfered with the lives of millions—millions, not thousands—of individuals. These un-American, unethical, unscientific attitudes and practices have frustrated legitimate aspirations and smashed even the modest hopes of millions of our fellow citizens for a chance at a decent way of life.

There is no need to recount how prejudices develop; how the new-born babe has no such "anti's" engraved upon his cortex; how thoughtless parents, friends, and neighbors lead the growing child into warped social attitudes; how fiction, films, plays, cartoons, vaudeville, radio, and the rest have helped perpetuate monstrous lies into fixed stereotypes. Nor is there any need to remind ourselves of the vicious rôle that the habit of generalizing plays in our thinking—the fact that it is most unscientific to say that *all* Negroes or *all* Irish or *all* Italians or *all* Catholics or *all* Jews or *all* Protestants are this way or that way.[1]

Nor, finally, is there much need for us to recall that not only do prejudices derive from a failure to examine honestly the facts in the case, but that they stay alive because of a feeling of insecurity or frustration within the breast of him who is prejudiced.

We Americans often pride ourselves on being a practical people—a people with our feet on the ground. "Show them where it is to their self-interest," says the sales-promotion executive, "and they'll buy!"

How strange, then, that we overlook the fact that in the final analysis ethical conduct and self-interest are really synonymous processes! Even the Golden Rule is based upon the recognition of that truth: *"Do unto others as you would have others do unto you!"*

Were prejudice a static phenomenon, the only one harmed would be the individual who harbored the prejudices. Prejudice, however, is dynamic and spreads in two directions, constantly gaining new adherents and constantly increasing the number and variety of targets. It would be fortunate, indeed, if those harboring serious prejudices could refrain from expressing their prejudices in one or another form

[1] See "The Interdependence of Democracy and Mental Health," by Julius Schreiber. MENTAL HYGIENE, Vol. 29, pp. 606–621, October, 1945.

of discrimination. Stern reality, however, prohibits us from stating that such an inhibitory practice is common. To-day, it is the Negro who is the victim; the next day, the Catholic; and the next, the Jew, or the foreign-born. Prejudice, like any contagious disease, can and does spread.

The brutal truth is that it is *not* to our self-interest to indulge in discriminatory practices against members of minority groups. Unemployed, insecure, ill-fed, ill-housed, and ill-clad fellow citizens pull down the rest of the economy. Says Eric A. Johnston, President of the United States Chamber of Commerce: "Whenever we erect barriers on the grounds of race or religion, or of occupational or professional status, we hamper the fullest expansion of our economic security. Prejudice doesn't pay. Discrimination is destructive."[1]

And think of the loss to our national culture because hundreds of thousands are driven by discrimination to live crushed and embittered lives!

Since primitive times, "scapegoating" has been a horrible social device employed by frightened oppressors and power-hungry schemers. And at one time or another, in world history, practically every minority group has been used as a scapegoat, has suffered from prejudice, discrimination, and persecution, and in turn has caused suffering.[2]

Even those who are prejudiced will very often agree that a man *should* be judged on his merits and that his race, creed, or color *ought* not enter into consideration, yet to act on such a recognition is, for some, quite a difficult thing to do. The problem is to implement the ethical point of view. And that, for many, calls for a strong emotional catharsis, a purging of blind spots—or for some form of social shock therapy that forcibly demands a truly ethical mode of conduct.

Such social shock therapy was seen during the war just concluded. Out of sheer life-and-death necessity combat

[1] In an address on "Intolerance" before the Writers' War Board, New York City, January 11, 1945.

[2] See *They Got the Blame—The Story of Scapegoats in History* (New York: Association Press, 1944); *All in the Name of God*, by Everett R. Clinchy (New York: John Day Company, 1934); *From Many Lands*, by Louis Adamic (New York: Harper and Brothers, 1940); *Probing Our Prejudices*, by Hortense Powdermaker (New York: Harper and Brothers, 1944); and *An American Dilemma*, by Gunnar Myrdal (New York: Harper and Brothers, 1944).

soldiers, and to a certain extent civilians, had to rid themselves of their prejudices. Working together throughout the war taught many of us that our prejudices were extremely dangerous and that only coöperation paid off.

But many did not learn this lesson during the war. Many are succumbing, again, to former prejudices or picking up new ones. For these, the challenge of the trying years that lie immediately ahead seemingly does not constitute a sufficient threat. However, one little event, when fully understood, will provide shock therapy enough. And though I certainly love my fellow men, I join with every miserable misanthrope in his gleeful rejoicing over the arrival of man's final certainty of complete self-destruction—the atomic bomb! Physical scientists have forced unsuspecting man to leap upward into a higher plane of life, but social scientists may well tremble over the prospects of man's ability to live within this new framework.

I have no lack of faith in the basic capacity of human beings to live in an atomic age. But this calls for an assumption and actual application of higher ethics. We little human creatures, crawling about on this small planet, having finally devised the means for our mutual self-destruction, have got to stand up straight and walk straight—and walk *together!* Pitifully small and petty isolationist talk of "we ought not share it" is meaningless. *There is nothing to share but death* or—at long last—a truly functioning *brotherhood of man!*

What is it, then, that psychiatrists, psychologists, social workers, and others who work in the field of interpersonal relations can do about this problem?

First of all, as citizens in a democracy, we have the same responsibilities that all other citizens have. We are obliged, therefore, to participate in any effort directed toward diminishing the gap that exists between our democratic credo and our daily practice.

But more specifically, as professional people who enjoy both prestige and influence in the community, there are some definite things that we can do. As individual professional people and as members of professional organizations, we can record our approval and actively support any and all efforts aimed at the eradication of discriminatory practices.

In several of the publications of The National Committee for Mental Hygiene there appears a statement on objectives and procedures. "Our organization," states the prospectus, "is constantly seeking to enlarge its own knowledge . . . and to educate the public both as to the general meaning and purposes of mental hygiene and as to its relation to education, medicine, industry, delinquency, and dependency. . . . In the broad field of human behavior there is nothing that is not in some way connected with the science of mental hygiene."

Meetings such as these are definite proof that psychiatrists—or at least some of us—are more than just academically concerned with these questions. But the problem calls for more than meetings at which papers are presented. One might be very well justified in questioning the effectiveness of psychiatrists in the field of mental-hygiene education when there are such shameful incidents as those that have occurred in Detroit, Philadelphia, Boston, New York, and elsewhere. And, further, one looks in vain for loud, effective protests from organized psychiatry when such undemocratic practices break out.

How closely do we psychiatrists watch the curricula in our school systems? To what extent do we register effective protest when we learn of school-teachers who are themselves victims of morbid prejudices and who frequently translate their prejudices into schoolroom life?[1]

And do we effectively register our protests against subversive elements who would disrupt our democracy? Do we join hands with progressive groups in a common fight against individuals or organizations who spread poisonous, undemocratic ideologies?

And how have we registered our stand in behalf of progressive legislation? National and international issues that are clearly related to the physical, mental, and social welfare of our fellow citizens are of primary concern to us. Do enough of us promote such legislation? Do enough of us go out and fight for it? Do we make ourselves heard?

One often hears the warning cry, "You can't legislate

[1] See *Intercultural Education in American Schools* by E. Vickery and S. G. Cole. New York: Harper and Brothers, 1943.

mores!" and we are hastily reminded that "prohibition failed."

The folkways of people are of course extremely interesting, and yet—often enough—many are brought into existence, seemingly overnight, by nothing more than the passing of a law!

One of the folkways of many of our states happens to be that young children are kept in school rather than in the cotton fields or sweat shops. We are proud of that folkway, yet it took a variety of child-labor acts to establish it.

One of our national folkways is to give wage earners an eight-hour day and the right to bargain collectively. We take special pride in these folkways—yet it took some plain and fancy legislation to bring them about.

"You can't do this!" "It's unconstitutional!" "It's against 'states' rights'!" Such protests, expressed in one fashion or another, are commonly heard whenever proposals for some kind of progressive legislation are introduced. To-day, as we look back over a host of laws that have clearly changed our attitudes, our ways of thinking, our *mores*—when we look back and see how well these laws serve the total community, they seem so "natural" that one finds it difficult to believe that there was serious opposition to their enactment. The Sherman Anti-Trust Act, the Federal income tax, women's suffrage, the Inter-State Commerce Act, the Pure Food and Drug Act, the National Labor Relations Act, Social Security, fair labor standards, national housing, Security and Exchange, and dozens of other vitally important pieces of legislation—all of these have served the country well and have become an integral part of our social thinking and yet, in each instance, there was a considerable fight before the legislation was finally enacted.

One cannot legislate *mores?* Ridiculous! *Mores* can and do bring about new legislation—but *legislation can and does bring about new mores!*

And now alarming cries are raised again when it is proposed to legislate a permanent F.E.P.C. It is interesting how the success of F.E.P.C. during the war is conveniently overlooked. It is also of significance that most of those who utter dire warnings of violence and strikes and walk-outs are

rarely, if ever, seen in the front ranks of any progressive efforts.

There is a good three-point test formula that one might put to any proposal for social legislation: 1. Is it in keeping with, or an extension of, democratic principles? 2. Can what is proposed actually work in practice? 3. Is it necessary on the basis of objective social conditions?

And that in the final analysis is the heart of the question. If we are proposing legislation that seeks to make a practical application of a democratic principle, and if that legislation is a down-to-earth proposal that can actually work out in everyday life, and finally if it meets the needs of objective social conditions—there is no other course but to get behind it and push for it.

It is perfectly true that it would be very nice and sweet if one could have 100 per cent public support for a proposed law. And there are those who argue that one should hold up legislation until the people are *educated* to accept the new law. Such an argument overlooks the tremendous educational process that exists in the very act of passing a progressive piece of legislation. When undemocratic practices exist and the government fails to establish the fact that such practices are illegal, it actually does more than merely condone such undesirable practices—it furthers their extension and growth. Conversely, when progressive legislation is passed, there is a healthy experience for *all* of the people.

First of all, *timid liberals take courage.* It is no longer necessary for them to whisper their beliefs. They may shout them from the house tops because the law of the land is on their side. Secondly, *confused people get clarification.* They see in practice the actual workings of a proposal about which they had little practical information. And finally, *progressive social legislation tends to inhibit the scoundrel.* For now the tight shoe is on his foot. It is he, rather than the man who fought for the issue, who must tread softly and go about talking in whispers.

Let me conclude with this summary: The damage that prejudice and discrimination do both to the *victim* and to the *aggressor* is well known to all of us. Prejudice derives

from ignorance and is kept alive by deliberate mischief for the economic gain or the psychological needs of warped, insecure, or frustrated aggressors; it is exploited by demagogues who seek political advantage and power; it draws strength from morbid social values; and finally, it finds blessing in negligent government.

For while it is quite true that a law cannot tell an individual, "You may not dislike or hate a man because of his race, creed, color, or ancestry," it can and should say, "You may not *implement* your prejudices to the detriment of your fellow man."

When laws will speak in such a fashion, Democracy, rather than native-brand Fascism, will speak for America.

Let us not mince words. Fascism preaches the idea, among others, that some peoples are inferior to others. Fascist philosophy and methods of operation are not indigenous to the soil of Germany, Italy, or Japan. We, in America, have seen ample evidence of native Fascism. And having finished with the shooting phase of the war of Democracy versus Fascism, let us get on with the business of eradicating Fascist manifestations at home.

We psychiatrists like to believe and say that we are experts in the field of human relations. Let us, then, live up to our responsibilities. Let us assume our inescapable obligation to make ourselves heard; and let us join hands with other responsible citizens and groups in our over-all common fight to make democracy work.

Democracy can work! But we have to make up our minds that it will cost a lot to make it work—a lot of effort, a lot of courage, a lot of money, and a lot of emotion. But it will cost us everything if we fail!

LEGAL SANCTIONS AGAINST JOB DISCRIMINATION*

CAROLINE K. SIMON

Commissioner, New York State Commission Against Discrimination

THE Bible emphasizes the dignity of individuals. We Americans believe that Biblical emphasis on the dignity of the individual is part of the basic thinking of the American people. In this country, we believe that men and women have the right to grow to their fullest development. The American creed, fundamentally, is this belief that all men are created equal. Equality cannot be legislated, but equality of opportunity can be.

The democracy we prize is an empty word unless it means the free recognition of ability, native and acquired, whether it be found in rich or poor, alien or native, black men or white.

Governor Thomas E. Dewey, on September 30th of this year, stated the facts clearly: "The attitude of nations to the problem of minorities is a touchstone to their approach to other and wider problems. Unless a society bases itself on a sincere acknowledgment of its responsibilities to the weak as well as to the strong, it will, in the inexorable process of the passage of time, perish."

Myrdal, in *An American Dilemma*,[1] found that social scientists in this country had developed a defeatist attitude toward the possibility of inducing social change by means of legislation. New York State has courageously indicated that it does not share that attitude and has evidenced its belief by the enactment of Chapter 118 of the Laws of 1945, popularly known as the Ives-Quinn Law, which establishes a commission against discrimination.

Whenever there is a legislative milestone of this kind, it takes calm adjustment, careful planning, and conscientious

* Presented at the Thirty-sixth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 1, 1945.

[1] New York: Harper and Brothers, 1944.

effort to put the new law into effect. It takes also thorough understanding of the law by the citizens of the state, and a determination on the part of all the people to support a fair administration of the law.

To a group such as this it is unnecessary to state that it is the popular beliefs, and those only, that enter directly into the causal mechanisms of interracial relations. You know that to understand race conflict we need fundamentally to understand conflict and not race.

New York State holds a proud position as the Empire State, the state that leads in industries, in population, in income. For example, this state led in the number of placements of physically handicapped workers in 1944. The wage and salary payments of employees in private industry in 1944 reached the staggering total of over ten billion dollars. New York State leads also—and perhaps this fact is more closely related to the other than superficial thinking might reveal—in its social legislation. As further evidence of that leadership, the state has led in enacting the legal sanction against discrimination.

The Law Against Discrimination, pursuant to which the State Commission Against Discrimination was created, became effective July 1, 1945. The commission appointed in accordance with the provisions of that law consists of five members appointed by the governor with the advice and consent of the senate. During the first four months, the work of the commission has centered about four major spheres of activity: (1) organizational activities; (2) the rendering of advisory opinions and decisions; (3) the formulation of rules and regulations and the establishment of policies, practices, and procedures; and (4) the promulgation of plans for coöperating with state and federal agencies, the institution of educational programs, and the establishment of advisory councils, and so on.

The State Commission Against Discrimination has established three offices in different sections of the state of New York. The principal office is located at 24 James Street, Albany; a second office at 65 Court Street, Buffalo; and a third in New York City, its temporary location being 124 East 28th Street. These offices are open to the public during regular business hours for the purpose of receiving complaints and rendering advisory opinions. On Wednesday

of each week, all offices are open from 9 A.M. to 7 P.M. as a convenience to persons who are unable to attend during regular business hours.

Office procedures have been established to expedite the handling of cases. Complete integration of activities among the three offices of the commission is effected.

The Law Against Discrimination is not retroactive. To give the commission jurisdiction over an employer, an employment agency, or a labor organization chargeable with an unlawful employment practice, the discriminatory act must have occurred subsequent to July 1, 1945. Furthermore, this commission has no jurisdiction over federal agencies, clubs exclusively social, or fraternal, charitable, educational, or religious associations or corporations not organized for private profit, nor does it include any employer with fewer than six persons in his employ or domestic service.

The law specifically states in Section 131 that it shall be an unlawful employment practice:

> "1. For an employer, because of the race, creed, color or national origin of any individual, to refuse to hire or employ or to bar or to discharge from employment such individual or to discriminate against such individual in compensation or in terms, conditions or privileges of employment.
>
> "2. For a labor organization, because of the race, creed, color or national origin of any individual, to exclude or to expel from its membership such individual or to discriminate in any way against any of its members or against any employer or any individual employed by an employer.
>
> "3. For any employer or employment agency to print or circulate or cause to be printed or circulated any statement, advertisement or publication, or to use any form of application for employment or to make any inquiry in connection with prospective employment, which expresses, directly or indirectly, any limitation, specification or discrimination as to race, creed, color or national origin, or any intent to make any such limitation, specification or discrimination, unless based upon a *bona fide* occupational qualification.
>
> "4. For any employer, labor organization or employment agency to discharge, expel or otherwise discriminate against any person because he has opposed any practices forbidden under this article or because he has filed a complaint, testified or assisted in any proceeding under this article.
>
> "5. For any person, whether an employer or an employee or not, to aid, abet, incite, compel or coerce the doing of any of the acts forbidden under this article, or to attempt to do so."

The commission has reviewed hundreds of blank employment application forms submitted by employers throughout the state. The object in each case is to determine whether

there are any questions or requirements set forth on the form of application for employment that violate the language or intent of the Law Against Discrimination.

Advisory opinions have been rendered adjudging the following queries by an employer as unlawful employment practices:

1. Are you a native-born citizen?
2. Where were you born?
3. State address of your relatives.
4. State the place of your national origin.
5. What is your religious affiliation?
6. To which race do you belong?
7. State your complexion.

The following queries by employers have been held by the commission *not* to constitute unlawful employment practices:

1. Are you a citizen of the United States?
2. Is your mother a citizen of the United States?
3. Is your father a citizen of the United States?
4. What is your mother's maiden name?
5. Have you the ability to use a foreign language?

The commission has held that a requirement by a privately operated language school that teachers of foreign languages must have been born and have received their education in a country wherein such language is spoken does *not* constitute an unlawful employment practice. The query is an attempt by the employer to ascertain the existence of a *bona fide* occupational qualification which is expressly permitted by statute (Sec. 131, subd. 3).

The commission has also held that a requirement by an employer for a photograph of a person *already in his employ* does *not* constitute an unlawful employment practice.

On August 14, 1945, there was forwarded to the secretary of state a set of rules and regulations governing the practice and procedure before the State Commission Against Discrimination. These rules and regulations are available to the public. The law specifically states that the complainant must swear to the truth of his statements. This is intended to prevent the filing of frivolous or unwarranted complaints. After a verified complaint has been filed, either by the person claiming to be aggrieved himself or by his attorney at law, stating the name and address of person, employer, labor organization or employment agency alleged to have com-

mitted the unlawful employment practice, the chairman of the commission then designates one of the commissioners to make, with the assistance of the commission's staff, prompt investigation in connection therewith. If the commissioner determines after such investigation that probable cause exists, he endeavors to eliminate the unlawful employment practice complained of by "conference, conciliation, and persuasion." No disclosure is made of what happens in the course of such endeavors.

In case of failure to eliminate the unlawful practice, or even in advance thereof if circumstances so warrant, the commission may cause to be served in the name of the commission a written notice together with a copy of the complaint, requiring the person, employer, labor organization, or employment agency named in the complaint, to whom we refer as a respondent, to answer the charges of the complaint at a hearing before three members of the commission. The commissioner who has previously made the investigation and caused the notice to be issued does not participate in the hearing except as a witness.

After all the evidence has been taken at the hearing, the commission, if it finds that the respondent has engaged in any unlawful-employment practice as defined in the law, is required to state its findings of fact and to cause to be served on the respondent an order requiring him to cease and desist from such unlawful employment practices. If, however, upon all the evidence, the commission finds that the respondent has not engaged in any such unlawful employment practice, the commission may dismiss the complaint. There is a statute of limitations in the law in that any complaint filed pursuant to this action must be filed within ninety days after the alleged act of discrimination.

The person who claims to be aggrieved by the order of the commission may have judicial review thereof in the supreme court of the state.

Among policies adopted by the commission to govern its operations are the following:

> 1. If, after the referring of a complaint to a commissioner, he shall determine that the commission is without jurisdiction, he may on his own motion dismiss the complaint without referring it to the commission as a whole.
>
> 2. Where the complaint is against the action of a fellow employee or against the immediate supervisor or foreman of the complainant,

and the complaint does not allege an act of discrimination based on race, creed, color, or national origin, and where from the facts in the complaint it appears that people of similar race, creed, color, or national origin are employed by the employer, the complaint may be dismissed or closed without further action.

3. In cases in which there is an express allegation in the complaint that the treatment accorded the complainant is due to his race, creed, color, or national origin, or where it appears from the allegations in the complaint that other employees of similar race, creed, color, or national origin are subject to discriminatory treatment, further investigation will be ordered.

4. In a case where a complaint is filed by an attorney on behalf of an individual complainant, an authorization for the attorney to act, duly acknowledged by the complainant, is required. The commission has adopted a form of authorization and acknowledgement for use in these cases.

5. In all cases in which respondents have been advised that complaints have been filed against them, they will also be advised of the final decision of the commission. There is no publicity given to the name of the complainant or respondent during the period of investigation or conciliation unless conciliation fails and the matter must under the law proceed to a hearing. The provisions of law demand secrecy.

6. Firms claiming exemption from the operation of the Law Against Discrimination on the ground that they are engaged in government work and therefore are entitled to what the law describes as a "*bona fide* occupational qualification," may file a request for such a qualification.

The commission has promulgated and set in operation numerous programs looking toward the elimination of discrimination in industry, sports, and other fields of human relations. These programs, briefly stated, are as follows:

1. The establishment of advisory councils composed of representative citizens in key communities throughout the state of New York, who shall serve without pay and aid in fostering, through community effort or otherwise, good will, coöperation, and conciliation among the groups and elements of the population, as provided in Section 130, subd. 8 of the Law Against Discrimination. These advisory councils will be particularly requested to do educational work in cases of discriminatory acts not covered by the law.

2. Coöperation with and recommendations to agencies and offices of the state and local subdivisions of government for the purpose of effectuating the law as set forth in Section 129 of the Law Against Discrimination. The executive division of the state of New York has been requested to ask that all state application blanks and forms be checked and all discriminatory references eliminated therefrom. Forms of the Workmen's Compensation Board already have been checked and all reference to race eliminated. This reference formerly was included for statistical purposes, but a reëvaluation of the inquiry indicated that the statistical needs did not outweigh the desire to meet the purposes and intent of the Law Against Discrimination.

3. The Law Against Discrimination does not cover agencies of the federal government. However, contact has been established with army officials of the Second Corps Area, the army air corps, and the navy, all of whom have agreed to coöperate with the commission. Contact has similarly been made with the F.B.I. and coöperative methods of functioning have been established.

4. A directory of trade organizations is in process of preparation to be used by the commission in developing non-discriminatory programs affecting the entire industrial field.

5. Letters have been sent to employers of 100 employees or more throughout the state and to organizations of industry and employers in general, requesting that a printed notice, prepared by the commission, be posted by them announcing to their employees their intent to comply with the Law Against Discrimination.

The phase of the law relating to compliance is limited specifically to discrimination in employment. The law authorizes, as part of its educational program, the study of problems of discrimination in all or specific fields of human relationships or in specific instances of discrimination because of race, creed, color, or national origin. The commission also is authorized to foster through community councils good will, coöperation, and conciliation among the groups and elements of the population of the state. The councils may make recommendations to the commission for the development of policies and procedure in general and in specific instances, and for programs of formal and informal education which the commission may recommend to the appropriate state agency.

The commission also is empowered to issue such publications and such results of investigations and research as in its judgment will tend to promote good will and to minimize or to eliminate discrimination because of race, creed, color, or national origin.

These are the legal sanctions that the people of the state of New York have had the vision to enact into law. Thus the state has reaffirmed its belief in the supreme significance of each individual man and woman in our free society. This law, among its other results, opens up to employers a large new group of employees from which to select qualified personnel. We, the State Commission Against Discrimination, pledge to you just administration of the law; from you we ask understanding of its purposes, compliance with its provisions, and support by your actions of the American ideals expressed in it.

HELP BOLSTER THOSE WAR MARRIAGES

W. EDGAR GREGORY

Executive Director, Commission on Ministry to Service Personnel and Veterans, San Francisco Council of Churches

DURING the hysterical war years we sowed the wind; now comes the harvest of the whirlwind. Many marriages took place that even at the outset had poor chances of success. Any experienced person could have foreseen the difficulties ahead, and any impartial and objective marital counselor could have shown by relatively well-established tests that these marriages had "poor predictability."

Several factors contributed to this. The war was a catalytic agent which stirred up many of the ingredients of our social life to a greater activity than would have normally occurred—though the tendencies were already there. Even normal, healthy processes were frequently hastened. Romances of long standing, which would probably not have culminated for many more months, suddenly reached fruition. As the young man faced induction into the military service, he and his fiancée frequently decided that it might be "now or never." Each frequently had fears of losing the other if marriage were not immediately consummated. In most cases these marriages have good "predictability."

The same processes that hastened these normal occurrences also brought about others far less desirable, however. The fear of the young man that he might never return frequently prompted him to taste the joys of marriage even though under circumstances he himself would consider far from ideal. Any attractive young woman who happened to be available at the moment was all that he desired. To-morrow was far away and might never come. Or he might return maimed and be handicapped in the search for a mate. Better take the best available now rather than wait.

Similar reasoning quite often affected the girl. After all, a woman ages fast. She must capitalize upon her beauty while it is at the peak of perfection. Even though she doesn't

know the man too well, she'd better take her chance now rather than wait until after the war is over. This reasoning reached almost the stage of hysteria in those towns far from military installations where there were hardly any men of marriageable age left. Many girls actually migrated to centers where there were many service men in the hopes of finding "the man."

A second very fundamental factor of human nature colored the outlook of both sexes and led them to choose mates who were far from suitable for them. We are all inclined to seek out the most desirable available person of the opposite sex, no matter where we are. I have noticed it particularly with professional people. The school-teacher who could have had her pick among her college classmates frequently finds herself in a small town where she takes her pick of the men available. She gets the best, but the difficulty is that the best there may be less than the equal of some of the poorest from the college community she has just left. Doctors often do the same thing. Unable to marry in college, where he could have made a very desirable choice, the young doctor is inclined to marry the most attractive available nurse in the hospital in which he serves his internship—even though that nurse may not compare with the majority of the women in his college class. Ministers do the same thing. While they might have made a very worthy choice in college, they wait until they are in some rural parish and then marry the most attractive local girl available—who may not compare at all with the women previously known.

So it is with the service man. A young man of good family and training may find himself stationed near some small town, where he makes the acquaintance of the most attractive available young woman and woos her. He may in his own mind know that she will not fit into his home community, but rivalry with his buddies drives him to try to win her affection. The problems of adjustment are serious enough when he thus marries into a segment of our own society with somewhat different cultural background than his own, but is much more serious when he marries some one from a different nation (as England, New Zealand, or Australia).

But over and beyond this, attachments are frequently formed with girls of *far* different cultural background. Not

a few service men have married Chinese or Japanese girls in Hawaii, Polynesian girls in Hawaii and the South Pacific islands, and Latin-American girls in Panama and the West Indies. Many of these marriages are frankly temporary. Others are planned for permanence, with the service man knowing that the only happy future for his family is for him to remain in his wife's community instead of taking her to his own.

Under this same war hysteria, girls have frequently been swept off their feet by the uniform. A young man who has no particular status in civilian society may yet make quite a presentable appearance in uniform. The glamour of such organizations as the Army Air Corps and the Marine Corps has caused many a girl to take a man with whom there is very little future. Sailors coming ashore after months at sea, too, have enormous sums of money to spend and do not hesitate to take a girl to the best places in town. Choosing a man who has only been known in uniform is a poor policy. It gives little indication as to what kind of civilian status will be his.

As a consequence of all this, families reunited after the war are going on the rocks in tremendous numbers. By all objective tests they should never have been established. The traditional and authoritarian view is that once they have been established, they must be continued. These couples took each other "for better or for worse," and if it be "worse," they can only blame themselves and put up with it.

Certain practical considerations, however, suggest themselves. A marriage that should never have occurred is not a true marriage and may cause more actual suffering if continued than if ended. Even in such cases, however, we should proceed slowly. Two particular factors must be emphasized:

1. Divorce is something that must be built up to—just like marriage. I know of one case in which the husband, after twelve years of marriage, was suddenly confronted by a telegram stating that his wife was in Reno applying for a divorce. He went on a long drunk which put him in a hospital for prolonged treatment. It might have been even more disastrous. Individuals thus suddenly confronted by the threat of divorce have been known to commit suicide.

Waller's studies in particular emphasize the fact that divorce is not the result of *one* sudden disagreement, but of a series of disagreements and attempts at reconciliation. From this point of view alone, these unsuccessful war marriages must be continued for a time, even though they will ultimately break up.

My own experience in dealing with returning service men is that the desire of their wives to divorce them—suddenly presented to them on their return—takes from them almost all desire to try to make a place for themselves in civilian society. And the desire of many service men to separate from their wives—after their discharge—and rejoin some girl they have associated with in their military career is often a serious shock to a young wife, who may have all desire to live taken from her by the blow. For this reason alone I try to persuade every couple—no matter how unhappy—to make at least one more try at reconciliation. They owe at least that much to the undesired mate—time to adjust to the new situation.

2. Even the most ill-assorted couple may, if they make a real try, find so much in common that their momentary desire to separate may be overcome. Any counselor who decides that two people already married are unfit for each other and should be separated is going far beyond his calling. Even though he may believe that they should be separated, he should encourage them to make at least one more effort to find something in common that will justify the continuation of their marriage. In the depths of their inner characters there may be elements in common that will make for a happy wedded life. Even divorced people have been known to reunite, after long separation, into very happy couples. And a person once divorced always has one strike against him—the sense of a failure in an attempt at marriage.

So, while many "war marriages" have been foolish, short-sighted, and even dangerous, the whole community should join in an effort to bolster them. Nothing will be lost and much may be gained. At the worst the marriage will but be prolonged for a few weeks or months. And even here a confused and bewildered personality may be saved from shipwreck.

THE VETERAN AND HIS NEURO-PSYCHIATRIC DIAGNOSIS*

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REHABILITATION of the physically and mentally disabled has become increasingly prominent among army and navy medical activities in the past two years. The surgeon general of the navy, Vice-Admiral Ross T. McIntire, who has always been alert to mental-hygiene problems, established the navy's rehabilitation program early in 1944, under the direction of Captain Howard H. Montgomery. Rehabilitation, in Captain Montgomery's words, "was interpreted as meaning all activities and services which may be required to supplement the ordinary or usual therapeutic procedures in order to achieve maximum adjustment of the individual patient, either for further military service or for return to civil life with the least possible handicap from his disability."[1]

Since adjustment is, in many ways, the special province of the psychiatrist and the mental hygienist, it was inevitable that the military psychiatrist should assume an important rôle in the rehabilitation programs set up in military hospitals and military convalescent hospitals. In the navy he has done so, coördinating his efforts with those of other medical and special-service officers as well as representatives of the American Red Cross, the Veterans Administration, the War Manpower Commission, and allied agencies.

While it is the function of a military psychiatrist to return to full or limited duty all personnel who can still render useful service, there is always a sizeable number of psychiatric patients whose separation from the army or navy is advisable. With this group the task becomes that of returning them to civil life as little handicapped as possible

* EDITOR'S NOTE: This paper was submitted and accepted before the end of the war.

[1] See "Rehabilitation," by Captain Howard H. Montgomery. *Hospital Corps Quarterly*, vol. 18, pp. 1–4, March, 1945.

by their illness *and by the fact that they have been given a neuropsychiatric diagnosis.* The dynamic mechanisms of psychiatric illnesses are such that the essential "cure" often lies in leaving the service and returning to the more familiar and secure environment of home, but the fact of having a psychiatric label sometimes creates new problems and often precludes the satisfactory adjustment to civil life that is sought for the returning veteran.

Whatever the specific problems of men with neuropsychiatric diagnoses, therefore, there are doubts, questions, anxiety states, and feelings of guilt or shame that the majority have in common. Since pressure of work usually precludes individual psychotherapy with such patients, the attempt is made to deal with them in groups. It is the conviction of many medical officers that considerable anxiety can be allayed and a significant mental-hygiene effect be produced by talks and open-forum discussions centering around the implications of having a neuropsychiatric diagnosis. The proper handling of these patients' doubts and fears may have most beneficial consequences for their subsequent civil adjustment, even though such group procedures constitute the most superficial type of psychotherapy.

The main body of this article consists of the material as actually presented—sometimes with asides or elaboration to meet specific situations—to groups of patients about to be discharged from the navy with neuropsychiatric diagnoses. Its content is derived from the needs of the men themselves, as revealed in interviews with the psychiatrist, informal talks or "bull sessions" with hospital corpsmen on neuropsychiatric wards, or conferences with Red Cross workers. The subject matter and the terminology have been modified after having been read and criticized by some patients and after having been used in talks leading into open-forum discussions.

Experience indicates that the principal ideas can be grasped by men of limited education or that, in a group situation, if not grasped by all, the important points are passed on in even more explicit G.I. language by those who do understand. In addition, patients, Red Cross workers, and chaplains have requested copies to be used as an aid in formulating letters to parents, wives, or other relatives of such patients. It would appear, too, that such material

is needed by community agencies—such as the Home Service Division of the Red Cross and family-welfare societies—that may be called upon to assist the returning veteran. From this point on, the material is self-explanatory.

DO YOU HAVE AN N-P DIAGNOSIS?

Hundreds of men and women are being discharged from the army, navy, and Marine Corps with what you hear called "PN," "N-P," or "psycho" diagnoses. This means that the trouble is nervous, emotional, or temperamental rather than mainly physical. About 35 per cent of all medical discharges from the services fall into this general group.[1] Many of you are puzzled or angry because you have such a diagnosis. Some of you are worried because you don't understand it. Some of you are ashamed and say that you can't face your family or friends. Others of you are simply bewildered and wonder why a man with *your* symptoms is considered an "N-P" case. Perhaps you would like to know more about these "N-P diagnoses" and what they mean? If so, this is for you.

Typical Questions.—First let us list some questions that many of you ask about these things, and then give brief answers to them. Fuller discussion will come later:

1. Does having an N-P diagnosis mean that I am crazy or "nuts"?

No. If you were "crazy" or insane you would still be in a special hospital under active treatment and not be in the process of being discharged from the service.

2. Does having an N-P diagnosis mean that I am liable to "go crazy" sometime?

No. Your chances of becoming insane are no greater than those of the average man or woman in your home community. If anything, your chances are less. You have already solved your emotional problems or conflicts in the symptoms you had or may still have. You will probably get better rather than worse in the future.

3. Am I "weak" because I have a "psycho" diagnosis?

That depends on what you mean by "weak." Nervous symptoms are largely the result of pressures or stresses on a person. There is a point at which any one will "crack" and show nervous symptoms. Some persons reach this point sooner than others. Besides, you can't use the standards of peace time. The stresses of military life are different, especially those of combat duty. No man can predict in advance how well he will be able to stand up in battle. In a broad sense, every one

[1] According to The National Committee for Mental Hygiene. The official figures are not available (1945).

has his weak points. Some cannot stand separation from home. Some crack up in positions of authority or responsibility. Some can't "take" marriage. Some are unable to stand old age. There are many stresses in the service: regimentation, isolation on tropical islands, boredom of long patrols, the suspense of many G.Q.s, and then combat duty itself, which few men can withstand for long without the nervousness of "battle fatigue" or "combat fatigue." The point is that a man's weak spots show up in different situations and under different stresses. What affects another man may not bother you; and the other way around. Some of the best combat troops were poorly adjusted as civilians, whereas many who "break down" before or during combat were well-enough adjusted civilians.

4. My symptoms are mostly physical, but I have an "N-P" diagnosis. Why is that?

Many physical symptoms *may* be due to nervousness. High blood pressure, rapid heart, "heart burn," "nervous indigestion," bed-wetting, and excessive sweating are examples of symptoms that may come from nervous tension. A man with symptoms of stomach ulcer may or may not have an ulcer that can be seen by X-ray, but in either case the basic cause for his symptoms may be nervous or emotional tension. Some doctors in general practice estimate that over 50 per cent of their patients are like that. They have all kinds of "physical" symptoms, but the roots of their illnesses may be worry, anxiety, domestic trouble, or other such problems. It is only to be expected that the greater hardships and dangers of the service will bring a nervous strain that some men will be unable to shake off. The symptoms of this strain will be different for different men, but some will show the effects of strain in these "physical" symptoms. Since the basic cause is largely psychological (that is, nervous or emotional), an "N-P diagnosis" is often made.

5. Will I get better after I am discharged from the service?

In all probability you will; but there will be some exceptions. Most men and women will soon get back to where they were before coming into the service. Once they get away from the sources of stress for them, their symptoms will improve or go away entirely. What they need is to get back into the groove of life at home. Even the men who have to be in "mental hospitals" for a while tend to improve rapidly. Over 60 per cent of mental-hospital patients from the armed forces are returned to normal civil life within three months.

Many men, however, will have some symptoms for months or even years. This will be true especially for men who have seen a lot of combat. Such men will have nightmares from time to time and they may continue to jump at sudden loud noises. They are likely to be irritable, restless, and generally jittery. But such symptoms need not prevent them from going back to work or to school.

Much will depend upon the man himself, his family, and other people around him. We shall say more about this later. Meanwhile, it is important to remember that some men were poorly adjusted before coming into the service. They were unable to hold jobs, or do well in school, or keep out of trouble in their communities *before* they enlisted or were inducted. It is not to be expected that such men will have been cured or reformed in the service. Their problems have

little or nothing to do with being in the service. A few may "find themselves" in the army or navy, but the majority will be just where they were before.

6. Are there any disadvantages in having an "N-P" diagnosis?

Yes, there are, but they are not as bad as you think. The disadvantages, such as they are, will arise from lack of understanding by employers, members of your family, or others in your home community who may have the same wrong ideas about "N-P cases" as you yourself may have had. To counteract this, a good deal of public education is going on right now in newspapers and magazines and through various social and other agencies in your home communities. As time goes on, there will be better understanding at home of your problems and how to deal with them. There will be fewer cases of prejudice, discrimination, or misunderstanding.

But there is much on the positive side. The "N-P" diagnosis will not affect your Civil Service rating or seniority provided you can hold your former job. The War Manpower Commission and the U. S. Employment Service will give you the same consideration as they will any honorably discharged veteran. Your chances for buying insurance will depend more upon your condition at the time of your insurance medical examination than upon the reason for your discharge from the service.

Some men, to be sure, will remain too nervous for some jobs. Employers will have to take that into account. Such men will have to look around until they find something they can handle. There will be various state and federal agencies to help in such situations, especially the employment services. As noted above, some men will have trouble, not because of having an "N-P" diagnosis, but because they have always had trouble. These men are no more restless or unstable for having been in the service. In general, the *man* will count for more than the *diagnosis*. What you can do will count for more than what was in your health record. We could give you hundreds of examples of men who had "N-P" diagnoses, but who are now back at their old jobs, at better jobs, or in school, and getting along O.K.

7. How many people are going to know my diagnosis?

It will *not* be on your discharge certificate. If your conduct and proficiency records have been reasonably good, you will get a "big" or "battleship" discharge—the best there is. The medical records of the service are confidential medical records. Your diagnosis and symptoms are no more public property than if you had been through a large hospital or clinic, like the Mayo Clinic. The Veterans Administration, however, has the right to look at your records *if* you apply for disability compensation or hospital care, but its records are likewise confidential. The War Manpower or U. S. Employment representative may want to know your diagnosis in order to help place you in the right type of job. If you have an "N-P" diagnosis, however, it is usually passed on, if at all, under the vague term "nervousness" or "battle fatigue." And these records, too, are kept confidential. Your Selective Service (draft) board is entitled to know the reason for your discharge, but its records also must be kept secret under the terms of the Selective Service Act itself. There is, therefore, no reason to expect that any one in your community will know your diagnosis,

except for reasons planned to help you, unless you yourself choose to tell.

8. Are there ways for "N-P patients" to get further help if they want it after being discharged?

Yes, in many ways. In the first place, honorably discharged "N-P patients" are entitled to the full benefits of any honorably discharged veteran. The Veterans Administration offers compensation for disability, hospitalization when needed, out-patient services (in some places), and other benefits. Under a new administration, the Veterans Administration will undoubtedly improve and extend its services for men who have had "N-P" diagnoses, especially in the matter of out-patient services—*i.e.* those for men who don't want or need to go into a hospital.

Under the G.I. Bill of Rights, opportunities are offered for special training, more schooling, aid in buying a home, a farm, or a small business, and an income during a period of unemployment after discharge. The War Manpower agency offers short-term training for jobs in war industries. It is up to you to ask your Red Cross or Veterans Administration or War Manpower representative about these rights and opportunities.

In addition, there are many offers of help, especially to men with "N-P" diagnoses. Most of the larger cities are setting up mental-hygiene clinics where you can get advice and treatment. Many social agencies (United Charities, family welfare agencies, etc.) have skilled psychiatric social workers and psychiatric consultants who can be helpful. These agencies are not "charity" in the old-fashioned sense; they offer services to any one who needs their help when they cannot afford a private specialist. Every good medical school has out-patient clinics, and you can get psychiatric advice at most of these. If you wish to see a civilian psychiatrist in his private office, consult your family doctor or call your local medical society or hospital for suggestions. You owe it to yourself to keep away from quacks. So-called doctors who advertise quick cures for anything are usually fakes. Nearly every good psychiatrist belongs to the American Medical Association through the local county medical society, and the majority of well-trained psychiatrists are members of the American Psychiatric Association. The Red Cross or any social agency in your community can usually give you leads as to the psychiatric resources in your neighborhood.

9. What is the meaning of my diagnosis?

This question has to be answered in terms of your own particular case. Don't compare yourself with the next fellow, even if he has the same diagnosis, and don't take too seriously what you hear in "bull sessions." In general, these diagnoses are a type of label. They stand for various ways in which men act, think, and feel when they are not their normal or usual selves. If one man is worried or tense, he may become blue or depressed. He gets one label. Another man gets irritated and has trouble with his mates or officers. He gets a different label. A third man has the idea that every one is against him or picking on him. He gets still a different diagnosis. A fourth man hears voices or goes off the beam entirely, and he gets still another diagnosis. People act, think, and feel differently under normal conditions, but these changes are, as we say, "within normal limits."

But such changes are greater when a man is emotionally upset or under great strain, and he may develop symptoms that are "outside normal limits." A given man may act, think, or feel differently at different times or in different places, depending upon what is going on, what is expected of him, whether he has confidence in his superiors and buddies, and whether he is getting his sleep and "three squares" a day. Of course, some people are "out of step," or "different," or unable to get along with other people, or given to funny ideas or strange fears even in normal times and in their own homes; but most of those people have been kept out of the service. Others get that way only under stress and strain, such as that of being out of their normal "groove," like fish out of water. Still others get that way only under the most severe pressures, such as being in the tropics for many months, or being on picket duty with suicide planes all around, or being in front-line combat duty in an invasion.

Thus an "N-P" diagnosis in the army or navy *may* refer to the way a man is when he comes into the service (and for which he is usually sent home); *or* to the way he becomes after a few weeks away from home in a military environment; *or* to the way he becomes after months of isolated foreign duty; *or* to what happens to him in combat because of the attacks of suicide planes or because of all of the terrifying sights, sounds, smells, and fatigue of battle.

To put it another way, your "N-P" diagnosis may refer to the way you are most of the time and have been, to greater or less extent, most of your life, or it may refer to the way you become *only under certain conditions* of military service. It may or may not apply to the way you *will be* after you have been discharged from the service and returned to your home. Later on we shall discuss the various diagnoses more fully.

Why All This "Nutcracker" Business, Anyway?—Before we go any further, we think you should know what psychiatrists are and what they are supposed to do in the service. This may give you a better idea why you are being discharged from the service. After that we can tell you something about the lingo psychiatrists use and about the particular label they have pinned on you.

In the first place, psychiatrists are doctors of medicine. They have had the same basic training as all doctors. Then, instead of turning to surgery, skin diseases, children's diseases, or some other branch of medicine, they have taken special training in the so-called nervous and mental diseases.

Years ago psychiatrists worked mostly with people with the most serious mental diseases, the "insane"—people who had to be put in state hospitals. This is not true to-day. Nowadays many psychiatrists rarely or never see an insane patient. Some work only with children who may be bed-

wetters, have night terrors, have temper tantrums, and so on. Some work with older children who are "behavior problems." Some work in connection with courts or prisons. Some try to help people who are unhappy in marriage, unsuccessful in business, too tense to make friends or to have a good time at parties, and so on.

Many men and women who are highly successful in business, politics, or professional life have been treated by psychiatrists at one time or another. They may have had strange fears (phobias) or ideas they couldn't get out of their thoughts (obsessions). They may have had unduly rigid ways of doing things or, for example, had to go back twenty times to be sure they had turned out the lights (compulsions). They may have been unable to "make the grade" sexually (impotence or frigidity) or had "nervous indigestion." None of these things, as you can see, has anything to do with "insanity." Psychiatrists often treat people for those seemingly "physical" symptoms (mentioned above) that really express anxiety or "nervous tension": constant fatigue, palpitations, rapid heart, excessive sweating, and other conditions in which other doctors have found no physical disease.

In World War I it was discovered that men who had been very nervous in civilian life or who had had "nervous breakdowns" earlier in life did not hold up in the service. It was learned also that men with certain symptoms or habits (such as severe tics, stuttering, keeping to one's self all the time, and so on) were not good risks for military duties. It was, therefore, decided at the beginning of the present war to put into effect a program of so-called "psychiatric screening" and to try to keep out of the service men who were considered poor risks for the strain of military life, especially combat. Psychiatrists know that many persons can get along well and do a good job as civilians, and yet not stand up in the army or navy, particularly in battle. It was the first job of military psychiatrists, then, to spot men and women who already had these symptoms or who seemed likely to develop them in the service. Such men and women were sent home, not as misfits or "nuts," but simply as unsuited for military duties. This was, of course, for the protection of the man himself as well as of the service.

The second important job of the psychiatrists has been

to care for those men and women who did develop "psycho" symptoms in the service. Some of these men and women should have been rejected at the outset, but managed to slip through the "screening"; others could not have been detected by the most skilled psychiatrist and only broke down under new and strange pressures. Many men had only temporary upsets and have been helped by a few interviews with a psychiatrist at mental-hygiene clinics set up in some camps and training centers. Others have "broken" only after the most intense combat experiences and are battle casualties just as much as men wounded in action. Every effort has been made to make psychiatric treatment available for these psychiatric battle casualties, and many men have been relieved of their worst symptoms by "sleep treatment" and other forms of therapy. Rehabilitation programs have been organized in order to get men in shape for a return to duty or to limited duty or, if they have to be discharged, for successful return to civilian life.

Many men who have had severe nervous or emotional upsets in the service do not realize how much the enemy deliberately set out to cause "nervous breakdowns" among our troops. Every marine who was at Guadalcanal between August and December, 1942, had a taste of this. The Japs in the jungles and the Nazis with their "psychological warfare" did everything in their power to stir up fear, create panic, spread false rumors, cause distrust of our allies, and bring about ill will between officers and men, between Jew and Gentile, and between Negro and white. These propaganda efforts, combined with loss of sleep, limited supplies, and the natural tensions and unavoidable confusion of combat, can be as deadly as bullets, causing men to "lose their nerve," "go to pieces," or have "nervous breakdowns."

Every man in combat is under emotional tension; if he isn't scared he's an idiot or he won't let himself face what he is feeling underneath. There is a conflict going on within him. One part of him is torn by a very deep instinct to get away, to "save his skin." Another part of him is pushed on by all of his training, his desire to stick with his mates, to do the job, to live up to his ideals. These conflicting forces inside a man sometimes meet head on or, to put it

another way, pull him apart. Where training, leadership, and morale are good, a man suppresses his impulse to run; he goes on and does the job.

When morale is bad, or when a man is caught in his own line of fire or sees his buddy shot up, or when his make-up has been previously weakened by childhood fears or insecurity, then he may "break down" into some sort of "N-P" illness. One psychiatrist has said, in effect: "It might be more sensible to ask why men do *not* break down in combat rather than to ask why they do!" In any case, when men do "go to pieces"—to greater or less extent—it is the psychiatrist's job to help them to the best of his ability under the conditions in which he has to work.

What Do These "N-P" Labels Mean?—There are between forty and fifty possible "N-P" diagnoses in the army and navy books and we cannot list them all here. There are a few—like enuresis (bed-wetting), somnambulism (sleep-walking), motion sickness (seasickness), and epilepsy (fits, convulsions, or fainting spells)—that represent special problems in the service. The bed-wetter, for example, may have such a rugged time in a barracks or aboard ship that he becomes a problem in morale. The sleep-walker in a fox hole is too easily mistaken for a Jap and is in danger of being shot at night. The man with seizures is hardly safe aboard ship and is too much of a risk in any military organization. Men with such symptoms are usually excluded from the service or are discharged if their symptoms are discovered.

Beyond these, most of the "N-P" conditions can be put into one of five groups. These are: (1) mental deficiency; (2) the psychoses; (3) the fatigue states; (4) the psychoneuroses, or neuroses for short; and (5) the personality disorders or, as they used to be called, the constitutional psychopathic states. Here we can say just enough about these five groups to give you an idea as to why you were so classified.

Mental deficiency is not a very common diagnosis. It refers to what most people call "dumbness." Severe cases of mental deficiency are excluded from the service by their draft boards or at induction centers. It may be assumed,

then, that a man being surveyed from the service after some months or years of duty is *not* feebleminded, even though he is given the diagnosis of mental deficiency.

One has to remember that people who are dumb in some things may be smart enough in others. Men who go out of the service with a diagnosis of mental deficiency are often men who were merely poor in school work or who did not get a chance to go to school. Such men may be "dumb" in book-learning, but they may be as good as the next fellow in a job they know. They fall down in the army or navy because army and navy training in these days depends a lot on book work.

Besides this, men with little or no education often feel inferior to their buddies or shipmates who are better educated, and their "inferiority complex" becomes more of a handicap than their limited schooling. A man who can't keep up with the others often feels "out of the running" and may, therefore, become nervous and upset. Some men, too, "seem dumb" when they are only worried or upset for other reasons. It is well known, for example, that factory workers who are worried or who have family troubles make more mistakes and have more accidents at work than their fellow workers who are happy and secure. The same principle holds true in the service.

It may be said, then, that the majority of men discharged with a mental-deficiency diagnosis will be able to get along in civil life just as well as before they came into the service. These men have limitations so far as school work is concerned and should not be pushed if they are not doing well, but as workers they are often very steady and dependable, and many well-paying jobs will be open to them.

The group called the *psychoses* need not concern us here. The psychoses, in general, include all types of "insanity." Men who are as sick as that are retained in special hospitals until they are well, or nearly so, and then discharged. As noted elsewhere, a considerable percentage of such men are well enough within three months to be discharged into their own custody.

It is important for you to know, however, that a man may be "insane" for a few hours, days, or even weeks, and then get over it. With a very high fever, some people are

"out of their heads." During that time, they are psychotic—just like an insane person. Others may be psychotic for days after a severe head injury. They are "out of their heads" because the brain has been bruised by the injury and is temporarily swollen. Combat troops can become so upset by lack of food and water, by sheer physical fatigue, and by the sights, sounds, and danger of the battlefield that they go completely "off the beam" for hours or days. They, too, have a *temporary* psychosis, but most of them get 75–100 per cent better after rest, food, and water.

Sometimes a man is given his diagnosis at the height of his illness and later is surveyed from the service under the same diagnosis, long after he has returned to normal or at least improved greatly. The diagnosis then describes the mental upset the man *had,* not the way he is *now.* It is important to remember this point in connection with the diagnosis of psychoneurosis also.

The *fatigue states* include a number of conditions that go under the names of "exhaustion," "battle fatigue," "combat fatigue," and "operational fatigue." These diagnoses are usually given to men—previously well and free from nervousness—who develop symptoms only after severe combat experiences or after long tours of duty at sea, in planes, in submarines, in the jungle, or in lonely parts of the earth where it is all work and no liberty. The most common symptoms of the battle fatigue states are: combat dreams (nightmares), "startle" (jumpiness at sudden loud noises), restlessness, irritability, and general "nervousness" or jitteriness.

In these and the other fatigue conditions, the patient commonly complains also of headache, backache, painful legs, heart and stomach symptoms, and easy fatigue with any effort. It was first considered that the diagnosis of combat fatigue, for example, should be given only to men who had never before had nervous symptoms and who "broke down" under the pressure of actual battle conditions, but who recovered promptly when removed from the immediate battle zone and given rest, proper food, and help from a psychiatrist.

As it has actually panned out, however, a large number of men with the diagnosis of combat or operational fatigue have had at least *some* signs of nervousness for a good many

years—often from childhood—but not enough to bother very much. Perhaps they had nightmares or couldn't stand the sight of blood as children. Perhaps they were more tense than the average or more closely tied to home and parents. Such lifelong traits seem to make combat fatigue come easier.

Even "supermen," however, may develop combat fatigue if caught in their own barrage or line of fire, or if they feel that the odds against them are hopeless, or if they see their best friends blown up by mortar fire or a Baka bomb. Some men carry on for a long time after these experiences, and in some the symptoms appear only after they return to the United States and, especially, after they go home on leave or furlough.

There are many obscure reasons for these reactions, but the human mind can play strange tricks. Such illnesses are more than "fatigue states" in the sense that the man is just physically tired out; it is rather a matter of subconscious feelings of fear and guilt and horror that get the best of a man in spite of himself. Such men may not recover rapidly and are, therefore, discharged from the service as still too jittery for further duty. In such cases the diagnosis has to be changed to "war neurosis," "anxiety neurosis," "neurasthenia," or something else that simply describes the chief symptoms remaining after the more severe ones have cleared up during hospitalization, convalescence, and rehabilitation.

The *psychoneuroses* include a number of nervous illnesses or conditions that are serious enough to cause suffering, but not so serious as to be considered insanity. The rule-of-thumb difference between the psychoneuroses and the psychoses lies in the fact that the patient with a psychoneurosis knows who he is, where he is, and the fact that there is something wrong with him that he would like to get rid of, whereas the patient with a psychosis, who is usually more disturbed or more cut off from normal life, frequently does not know who or where he is and does not recognize that anything is wrong with him.

Psychoneuroses (called "neuroses" for short) are caused by emotional conflicts within the man himself. It is as if two parts of a man were at war, with neither side winning. Sometimes the conflict is between what a man *wants* to do

as against what he thinks he *ought* to do. Sometimes he is caught in some sort of emotional trap, and feels that he cannot escape. The problem is made harder because the man himself cannot see both sides of the conflict. One or both sides may be, as we say, subconscious. A person with a neurosis may be pretty upset (worried, anxious, fearful, unable to sleep) or he may have some unusual habits or symptoms that he himself knows are out of line or foolish, but he simply can't help himself.

Examples of neurotic symptoms include all sorts of "physical" symptoms without physical disease, excessive and unreasonable fears of dirt, syphilis, crowds, and so on; compulsion to do certain things, such as stepping on all of the cracks in the sidewalk, in order to avoid nervous tension; or intense feelings of fear or impending danger in really safe places. Few men or women are without some neurotic traits. Mental illness is largely a matter of degree. A few years ago a book was written and called *Be Glad You're Neurotic* on the grounds that most famous or highly successful people have had more than their share of neurotic tendencies. Some neurotic tendencies make for "drive" and success, but some, unfortunately, make for defeat, illness, and unhappiness.

It is important to remember, as mentioned before, that neurotic symptoms vary with conditions. Some neurotic men actually improve in the service, because they are at their best under conditions of danger and excitement. With most persons, however, it works the other way. The majority of already neurotic persons get worse when taken out of their usual groove. Others who have never been neurotic in civilian life—or at least have never seemed so—develop obvious symptoms under service conditions. Coming into the service puts a strain on even the most normal person and, for most, the strain increases the closer they get to combat. Separation from home and loved ones, the "glass-house" life of the barracks, regimentation, isolation from wives or girl friends, tropical conditions or life in foreign countries, and finally combat duty itself—all of these add more and more to the camel's back of a man's mental and emotional make-up, and for some the breaking point comes somewhere along the line.

Most men adjust to these changes one by one as they come along, but some men are still trying to adjust to one when another comes on them, and finally they may be overwhelmed. War makes for abnormal ways of living for every one, and the strains and pressures of war time are far worse than most people ever meet in normal civilian life. The neuroses of war are given the same names as the neuroses of peace time, but they are not the same because conditions are not the same.

It follows, then, that most men who develop even severe neurotic symptoms under the stress and strain of military life, especially under overseas and, most of all, under combat conditions, will be greatly improved, if not entirely well, after they have returned to normal civilian life.

Personality disorder and the *constitutional psychopathic states* are the hardest of all to define. The most common diagnoses in this group are (or have been in the past) "C.P.S., emotional instability," "C.P.S., inadequate personality," "C.P.S., schizoid personality" (now just plain "schizoid personality"), "constitutional psychopathic inferiority," and "personality disorder." These terms cover a lot of territory and, it must be admitted, psychiatrists do not see eye to eye as to what belongs in this group.[1] Much that will be said about this group could also be said about many patients with a psychoneurosis diagnosis. Some cases that Dr. X calls "emotional instability," Dr. Y might call "psychoneurosis, mixed type," or something else. The moral of this is that the labels themselves are not so important. What is important is the thinking, feeling (emotions), or behavior that the labels try to describe, and the deeper causes of such symptoms.

The severe personality disorders or "constitutional psychopathic states" usually have two things in common. In the first place, most men with such labels, through no fault of their own, have come from homes where things were not right. They have been sick or troubled or deeply unhappy

[1] One has to distinguish between what one school of psychiatry may define such terms to mean and how they are actually used in the service by hundreds of psychiatrists of different backgrounds and lengths of experience. The present discussion is based not merely on the writer's own usage, translated into nontechnical language, but also on his reading of some hundreds of psychiatric histories in navy health records from the service at large.

as children. Their homes have been broken up by death, divorce, separation, or alcoholism. They may have been "underprivileged" because of extreme poverty and neglect or they may have been "overprivileged" because of wealth, "spoiling," indulgence, or neglect. They may have been (or felt) unwanted and unloved by their parents. They have been "insecure" children, becoming "behavior problems" later on, and, in spite of outward appearances of defiance and bravado, they remain insecure, restless, dissatisfied, and deeply unhappy adults.

In the second place, most have this in common: Their symptoms are usually symptoms of disturbed behavior or misconduct, and they affect and disturb others more than they affect themselves. The neurotic man himself suffers from his fears, worries, anxieties, and so on, but with the "C.P.S. patient" the family, friends, community, or service suffers from his behavior. The neurotic usually wants help from a psychiatrist because he feels his symptoms keenly, but the "C.P.S." usually feels no need for treatment since he has no conscious suffering and tends to blame his environment for all his difficulties.

Symptoms in the personality disorder and C.P.S. groups are many and varied, and not all conform to the points just discussed. In a very large number of men described as "emotionally unstable" or "inadequate personalities," for example, there have been minor nervous traits for years, but these symptoms get worse and "stick out like a sore thumb" in the service. The symptoms are really neurotic, but the men are classified as C.P.S. because the symptoms have been present so long, usually from early childhood. "Schizoid personalities" are often very shy, unable to stand noise or excitement, overly embarrassed at being seen naked, easily upset; they tire out easily, remain homesick far beyond the average time, or have headaches all the time.

Such men have often been reared by nervous or sickly mothers or mothers who protected them too much from "hard knocks." A famous psychologist once divided all people into "tough minds" and "tender minds"; and the "tender minded" often do poorly in the service. There are many exceptions, depending in part on the assignment a man gets in the service, but by and large the "happy extravert" makes

a better soldier or sailor or marine than the "quiet introvert." When they fail in the service, such men may go out on a "C.P.S." or "personality disorder" diagnosis on the grounds that their "tender" or shy or withdrawn tendencies have been there since childhood.

Another group of C.P.S. patients are those who are just too young or immature. They haven't grown up yet, they are still kids, and they don't know the score. Some of these do grow up rapidly in the service, but some do not. Some will never grow up, no matter how old they get, because they can't learn from experience. Thus, it may be a matter of temporary immaturity due to youth and inexperience or it may be a permanent immaturity (dating back to how they were brought up) because of not knowing how to profit from mistakes and learn from experience.

Still another group includes men who have always been restless, unable to "settle down," or find a place to roost. These men are changeable, unreliable, unpredictable, unable to take routine or discipline, and always in rebellion against authority. In civilian life they "got by" by wandering from place to place or job to job, but in the service "you can't count on them." They always act on impulse, on the whim of the moment. They "take off" without thinking of what may happen a few hours or days later or of the consequences of their impulsive actions. The pleasures of *right now* come ahead of any plan for the future. They always resolve to be different and to do better, but they are not able to change; they can't profit from their errors. They are some of the most charming and likeable people in the world—when things are going their way—but they are past masters at getting people "down on them" and are often punished time and time again. But punishment, discipline, moral lectures, and good resolutions have little effect, and they take off again when the impulse hits them.

In the worse cases of "psychopaths," fortunately a small group, we have criminals (most of them), "queers," drunks, "lone wolves," and "sex perverts." This does not mean "worse" in a moral sense, but rather that their symptoms are more disturbing to themselves and to others; many can be cured or greatly relieved by psychiatric treatment. So far as the service is concerned, few of these men hold up

for long. Many are eliminated prior to induction and most of the remainder during the first weeks of training. They are simply too sick and too disturbing to others to last for long in any military organization.

As we have stated before, it is impossible here to define all of the "N-P" diagnoses in the book. Perhaps the best thing to do is not to take too seriously the label itself. In your particular case, you can figure out for yourself what the medical officer intended by your diagnosis if you can face frankly *why* it was or *how* it was that you were unhappy or upset or unable to get along with yourself, your mates, or your officers in the service.

What About Going Back Home?—We said in the beginning that some of you feel ashamed of having an "N-P" diagnosis and that you may feel you cannot face your family and friends. From what has been said since, you can see that you have nothing to be ashamed of. You will—most of you, at any rate—be honorably discharged veterans and you should act accordingly. Write off your diagnosis as "nervousness" or "battle fatigue" and try to get back to normal living. It you should need help from a psychiatrist, go to him just as you would go to any other doctor because of bad tonsils or rheumatism or bronchitis. We have suggested elsewhere how to get in touch with a good psychiatrist.

It is impossible to make rules that will apply to every man or woman going out of the service. We shall not begin any such tough assignment. But the following are a few suggestions—listed as "Don'ts" and "Do's"—that may be helpful:

DON'TS

1. Unless you have definite plans for school or for a job, don't stay away from home and friends because of your "N-P" diagnosis. If your record is good, you will have an honorable medical discharge—in the navy, a "battleship discharge," and they don't come any better. Take it accordingly.

2. Don't try to run away from your symptoms. If you still have them, they will go with you. Get expert help if you need it.

3. Don't plan to "just loaf a month" or "take it easy for a while." You probably don't need a rest after weeks in the hospital. Your month will become two months, then three. Then it will be really tough to settle down.

4. Don't think that your diagnosis excuses you from correct behavior toward other people and private property. You are still legally sane and responsible for your actions; otherwise the service wouldn't have

turned you loose. Remember to go easy on the liquor or leave it alone entirely. Many men with "combat fatigue" or "war neurosis," especially, get drunk on a few sips and are all too likely to mistake innocent civilians for Japs or Nazis. Don't foul yourself up that way.

5. Don't let the home folks baby you too much. It will irritate you or, if it doesn't, it will keep you sick longer than necessary. If you like it too much, you'll be let down sooner or later when the folks expect you to get down to business. If it irritates you, it may spoil your homecoming. Better tell the people at home to treat you as a grown-up with a few nervous symptoms that you can get rid of by getting a job and some hobbies.

6. Don't expect people at home to "understand." They can't understand because they weren't there. They live in a different world. Let them be helpful and friendly, but don't get mad because they can't understand what you've been through or how you feel about it.

7. Don't be surprised if things irritate you and upset you at times. You may want to kick the kid sister or wring the baby's neck. Explain how you feel, and go out and walk it off. You will not be so easy to live with yourself for a while, especially if you have had a lot of combat duty. You, too, have been in a different world. You are as much like a fish out of water in coming home as you were like a fish out of water when you first joined up and went to "boot camp."

8. Don't expect the world on a silver platter. You are going to be given a lot. It *may* be more than is good for you. You are going to hear all about your rights as a veteran and a hero. The nation can never repay you for what you have done. But don't *you* take that attitude yourself. It was your fate to have to do a dirty job, and you did your part to the best of your ability. Now start building your life where you left off. Use the veterans' benefits to make a new start, but don't let them make you into a chronic invalid or a permanent dependent of the government. The sicker you are, the bigger your compensation will be; in one sense, they pay you to stay sick. But the compensation will never be as much as you can make if you get well. Think it over. Do you want to be dependent on that compensation twenty years from now?

DO'S

1. Swallow your pride and go home.

2. Tell your people frankly that you have been nervous. Tell them your principal symptoms and that you may be a little hard to live with for a while. Let them make allowances up to a certain point, but they must not let you get away with murder or baby you too much. Tell them that, too! If you really work hard and still can't make the grade, get help from a psychiatrist.

3. Get a job or go back to school. The longer you put it off, the harder it will be. Get on your feet and be independent as soon as possible, even if it hurts a bit. It may mean your salvation for the next fifty years!

4. Get a hobby. If you are irritable, full of hate, and restless, do something active. If you can't stand competitive games, then saw wood, punch a punching bag, chop kindling. Pick up new interests: wood carving, stamp collecting, clay modeling, blowing a saxophone. Make plans for your spare time and go through with them.

5. Get your exercise. Walk, swim, play golf. Set your own pace, but do something that takes you out of doors. Push yourself if you need to, but, of course, don't overdo it.

6. Find some one who does "understand." The best person is another veteran who has been through what you have, or something like. Talk over things that you don't like to talk about with others. You've got to let off steam somehow; if you bottle it up, your symptoms will be worse and last longer. If you can't find a buddy, find any good listener. A good listener is any one who can listen without babying you, gushing at you, or asking a lot of silly questions. That person might be your girl, your dad, your preacher, or a friend. Some one outside the family is often better because they are not so emotionally involved in your life.

7. Remember that "a private pain in your belly or an ache in your soul is not to be mistaken for the nature of the universe or the law of God."[1] If you stew in your own juices too long, the world will move on, forgetting you, and leave you behind. What happened to you shouldn't have happened to a dog. But it did; it's water under the bridge; forget it!

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[1] With apologies to Bernard DeVoto of *Harper's Magazine*.

BOOK REVIEWS

PSYCHOANALYTIC THERAPY: PRINCIPLES AND APPLICATION. By Franz Alexander, M.D. and Thomas M. French, M.D., with Staff Members of the Institute for Psychoanalysis, Chicago. New York: The Ronald Press, 1946. 373 p.

This is the dilemma: the literature on technique is amazingly scarce, considering the output on the psychological aspects of medicine, particularly in psychoanalytic circles. Whatever variations in technique have been instituted, certainly those working with adults have contributed little, although the impression is that considerable variations in technique are practised.

Those working with children, however, through necessity have had to modify their approach because of factors that are not present in working with adults, so that a "freer," less ritualistic technique has evolved. These factors include parents, other adults, the school, etc. The varied levels of interests and types of interest in children are all conducive to contact with reality and flexibility in the means by which the transference is built up and therapy carried on. Verbalization is only one of many instruments used. Hence the contribution of the Chicago school is confirmed by the experience of the child psychiatrists, and the need for a flexible approach affirmed. This is an urgent need, for we are confronted with the necessity of helping many and distributing our skills and time more broadly than our facilities have enabled us to do heretofore.

From time immemorial, technique has given way to ritual, which in turn may obfuscate through rigidity the purpose of alleviating distress and pain quickly and effectively. In all science, with experience technique becomes less cumbersome and time-consuming. This Alexander, French, and their co-workers have had the skill and courage to work out over years of laudable effort, and here are some of their timely findings and recommendations.

One must remember the dangers of a static approach, its great security to the conservative. Its challenge, however, to the visionary is also there, and the Chicago Psychoanalytic Institute has accepted that challenge, and in so doing has moved forward the horizon of science and its power to help.

There is a certain logical planning in the book. Beginning with a short, succinct history of analysis and its various phases, with emphasis upon certain periods—such as those of cathartic hypnosis, waking suggestion, free association, transference neurosis, emotional

reëducation—we now can say we are in a period of recapitulation, with some changes in approach and circuiting made possible by research and daily clinical evaluation. To have the courage to review one's practices is the first step toward breadth of viewpoint and depth of effectiveness. It is a far cry from the years of early psychoanalysis, when it was involved in a pioneer effort, in an adventure into unknown territory, the colonization of a new mind concept. The path of technique in analysis, like all unexplored areas, had to be laid down first; then, with that as a starting line, some courageous souls branched out. Ferenczi, Rank, Adler, Jones, Fenichel, Rado, Kubie, and Alexander broadened the trail into wider paths. There have been, as in all exploratory procedures, a removing of obstacles, a flattening of hilly areas, and a tunneling through rather than a going around or over.

Flexibility of a high order is required, the flexibility that comes with the courage of experience. The questions as to how frequently one should see the patient, how deep the level of interpretation should be, how to manipulate the transference, what to work through, and what to keep repressed for a more timely moment or entirely, are by no means easy to decide, and constitute a constant challenge. Traditional procedures have a security to them that is extremely enticing. In essence, the panorama of therapy is under the analyst's constant inspection and active direction, and the classical self-unfolding of the psyche is accelerated or diminished as the clinical judgment indicates. Now this is referred to as "brief" therapy, a comparative term. The goal is always a workable adjustment to life and its responsibilities within the endowment of the individual.

Interruptions are deliberately planned, for application lags behind insight, and earlier terminations are planfully sought, to incite the natural endowments of the patient to take hold and work through—with supervision, it is true, but "remote" supervision. One of the criticisms aimed frequently at psychoanalysis is contraverted, for emphasis is placed upon extra-therapeutic experiences. The social climate of the patient is utilized and exploited and the whole therapeutic procedure is no longer as patient-centered and individualistic as in the first days of psychoanalysis. Other fields of activity are consulted and a coöperative approach organized. Psychosomatic medicine, the various narcosynthetic procedures, and group therapy have naturally evolved as incorporated instruments in therapy. This is a natural evolution, as a result of the background of the therapist and the steadily expanding knowledge of the application of psychoanalytic findings to the arts and sciences. Literature, painting, anthropology, and—all too little—sociology are fertilized and hybridized by the seeds spread on the wings of growing knowledge.

In this way some of the evils of specialization are mitigated. With it, of course, the therapist is burdened with responsibilities unknown before. Whether he will or not, the patient is a member of society and his awareness is confronted with that fact. While the traditional admonitions of no major change during therapy are still in order, the literature has definitely taken on a "moralistic" tone, and the analyst is more and more active as adviser. His admonitions are more flexible, although insistent "that no important irreversible changes in the life situation be made unless both therapist and patient agree."

Once the fundamental problems of the patient have been outlined by the therapist, then the element in all of the later phase of therapy is the broad base of experience which the therapist must build upon, familiarity with the dynamics of the various categories of mental illness, with the clinical contributions of research organizations, with certain constellations of physical diseases, such as peptic ulcer, asthma, hypertensive vascular phenomena, and arthritis. The criticism might be made that these formulations are tentative, some are incomplete, and some are still to be substantiated. But they are at least working hypotheses which can and often do accelerate the process of exploration and cure.

Dr. Alexander's broad concepts, with their philosophical overtone, their earthy soundness, set the tone for a compilation of contributions that are an essential part of every therapist's equipment. Dr. French, in turn, through his keen clinical sense, contributes a discussion of the transference phenomena and their manipulations that must be appreciated for its clarity and practicality. While these two contribute the major part of the book, it would be an injustice not to mention the worthy rounding out of their contributions by other staff members of the Chicago Institute.

The clinical material of the book is succinct and illustrative. Each contribution adds a special note, and the unity achieved is in itself a worth-while example for future investigations. Through the exploration of many and the coöperation of all, science moves forward. We need more of such contributions, more exploration, more courage to meet new knowledge and to review the old. These investigators have shown the way, making our path that much easier. Theirs has been a worthy and a commendable guidance.

EDWARD LISS.

New York City.

THE YEARBOOK OF PSYCHOANALYSIS. Edited by Sandor Lorand. New York: The International Universities Press, 1945. 370 p.

This volume, consisting of twenty-one papers by analytic writers on a wide variety of subjects, should be of interest to all psychiatrists, whether analysts or not. Most of the material has been published previously in journals or as portions of other books. The reviewer could discern in the selection of the articles no consistent tendency to present a general survey of psychoanalysis at present, or to point out the direction of its growth, though one chapter is devoted to current trends.

The first chapter is a discussion of dream interpretation, first propounded by Freud in 1923. This will probably not impress those familiar with *The Interpretation of Dreams* as adding substantially to the profound insight and originality there displayed. Some are likely to find conclusions as to the meaning of dream incidents rather arbitrarily reached, and many will be skeptical of the value, as *evidence,* in an incident recounted about the prediction of a fortune-teller and its relation to the possibilities of telepathy.

The chapter by Alexander—*Fundamental Concepts of Psychosomatic Research*—should be of particular interest to all physicians. The valuable distinction, made elsewhere by the author, between hysterical conversion and vegetative changes that are not symbolic, but are exaggerations or prolongations of normal physiologic response, is well and convincingly presented. The brief discussion of psychogenesis offered is excellent and should do much to dispel the confusion that has for so long prevailed on this subject.

Jones, in *The Concept of a Normal Mind,* raises the interesting question as to how pathologic is the surrounding society, ordinarily regarded as normal, from which the psychiatric patient is distinguished. Brill, in *Mourning, Melancholia, and Compulsions,* touches incidentally on the interpretation of neurosis and psychosis as creative efforts that fail, but that are, for all their morbidity, biologically significant and, in some respects, comparable with the successful efforts of those who influence the course of civilization. These two points, in their interrelation, bring up interesting questions. One is led to speculate on what part in psychiatric illness is played by ill-timed or tragically awkward, but not fundamentally abnormal, responses to the generally ignored morbidity of what is regarded as sane.

The book is recommended as a useful source of material for physicians who wish to keep in touch with psychoanalytic formulations. Whether or not these formulations contain solutions as absolute as is sometimes assumed, and whether or not some analysts treat Freudian

postulates as dogma, the reviewer agrees with one of those who contributed to the yearbook that Freud brought more of value to psychiatry than all the men who worked in that field before him. No one who deals with personality disorder can afford to lose touch with the continuing development of psychoanalysis.

HERVEY CLECKLEY.

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PRINCIPLES OF DYNAMIC PSYCHIATRY. By Jules H. Masserman, M.D. Philadelphia: W. B. Saunders Company, 1946. 322 p.

This book is a harbinger of the gradual integration of the psychological with the biological sciences. It is a sign that, just as psychosomatic medicine signifies the integration of psychiatry and psychoanalysis with medicine, so these disciplines are tending to fuse with fundamental biological knowledge. The book attempts to present a general dynamic theory of personality based on a critical review of the various contributing schools. This is done primarily from the point of view of the laboratory and theoretical scientist, and the various formulations are repeatedly tested by brilliant experiments with animal conditioning and behavior.

The first section of the book deals with the development of behavior theory. It discusses primarily the contributions of academic psychoanalysis, with case material to illustrate "neurotigenic" and psychotic dynamism.

The second section, after a critical review of current theories of behavior—especially reflexology, behaviorism, psychoanalysis, and Meyerian psychobiology—advances the author's general theory. This is based upon the following principles, as formulated by the author:

> "1. Principle of Motivation. Behavior is basically actuated by the physiologic needs of the organism and is directed toward the satisfaction of those needs.
>
> "2. Principle of Experimental Interpretation and Adaptation. Behavior is contingent upon, and adaptive to, the organism's interpretations of its total milieu, as based on its capacities and previous experiences.
>
> "3. Principle of Deviation and Substitution. Behavior patterns become deviated and fragmented under stress, and when further frustrated, tend toward substitutive satisfactions.
>
> "4. Principle of Conflict. When in a given milieu two or more motivations come into conflict in the sense that their accustomed consummatory patterns become incompatible, kinetic tension (anxiety) mounts and behavior becomes hesitant, vacillating, erratic, and poorly adaptive (neurotic) or excessively substitutive, symbolic and regressive (psychotic)."

The book is comprehensive, erudite, and scholarly. It is at its best in the presentation of what is positive. Much of the negative criticism of other theories is no doubt valid, but it may be questioned whether too much space is not devoted to it in a book written ostensibly for students. This applies equally to the work of Sheldon, Adolf Meyer, Watson, Freud, Pavlov, and so on. Sometimes the criticism seems to miss the point, as when masochism is presented as a rather fantastic idea and its usual causation in conscience reactions not mentioned. Or, again, psychoanalysis is mentioned as being insufficiently biological, in spite of the fact that sexuality was long its corner stone and that Freud explicitly stated that he endeavored to adhere to psychological descriptions of the phenomena studied as a matter of planned scientific approach, though fully aware that some day its fundamental psychological concepts would rest upon a physiological and biological basis.

In general, psychoanalytic theories are emphasized rather than Freud's major contribution—the painstakingly factual observation upon which he built his theory as a first rough working hypothesis in a new and difficult field. This emphasis on theory is due no doubt to the organization of the book, which builds up to the presentation of the author's own biodynamic theory.

The sample psychoanalysis, although valuable in demonstrating a great variety of psychological mechanisms, yields very complicated material and may be misleading to students. In the majority of cases, the major emotional patterns can be clearly discerned in a relatively simple form, which would better demonstrate what a powerful microscope psychoanalysis can be, as well as the concreteness and simplicity of its essential findings.

The animal experiments are brilliantly conceived and executed. The results, of course, cannot supplant, but must be reconciled and integrated with, the factual observations and, if possible, the theories of the various other clinical and experimental approaches.

Altogether, the book would seem to appeal to the experienced and seasoned worker rather than to the student for whom it is ostensibly written. The student will gain a fine critical survey of all related fields and a necessary tendency to synthesize this knowledge. On the other hand, he is immediately introduced to a mass of theories and criticisms and finally to a new formulation, all of which can be adequately evaluated only by the experienced and thoroughly read psychiatrist, especially as many of the theories are in such a state of flux that leaders in various fields have deliberately refrained from attempts to crystallize them.

The style, like the book, is rich, stimulating, and provocative, with a penchant for polysyllables. There is an extensive glossary of thirty-

nine pages. The bibliography of thirty pages, double columned, indicates the breadth of knowledge that the author correlates in his comprehensive presentation of the principles of dynamic psychiatry.

LEON J. SAUL.

Philadelphia.

MODERN ATTITUDES IN PSYCHIATRY—THE MARCH OF MEDICINE, 1945. Edited by the Committee on Lectures to the Laity, of the New York Academy of Medicine. New York: Columbia University Press, 1946. 154 p.

The six articles by as many authors in this volume compose the tenth annual Laity Lectures of the New York Academy of Medicine. They are preceded by a foreword by Dr. Cornelius P. Rhoads, and an introduction by Dr. Edwin G. Zabriskie.

The first lecture, by Dr. Iago Galston, is entitled *Psychiatry in the History of Medicine.* In this Dr. Galston traces the appearance of psychiatric concepts and practices from the time of Hippocrates down to the time of the Nancy School of Hypnotism. The work of Mesmer in forcing attention to the phenomenon of suggestion is seen as the turning point historically, through its influence upon Bernheim and Charcot and consequently upon Sigmund Freud.

The second lecture, *The Development of Psychiatry,* is by Dr. James H. Wall. In it Dr. Wall reviews the development of psychiatric practice for the past century and a half. Beginning with the moral management of the patient as a means of treatment, Dr. Wall traces the development of mental-hospital practice as it was influenced by the discoveries of micro-organisms, cellular histology, and pathology. The contributions of Adolf Meyer and Sigmund Freud are particularly emphasized. The modern shock treatments of Sakel, Meduna, and Cerletti and Bimi have stimulated interest in research in chemistry and physiology of the nervous system. Finally Dr. Wall describes the most important achievement of our time—the teaching in our medical schools of the psychiatric approach to the sick or troubled person, whether his illness is largely physical in nature or emotional and psychogenic in origin.

In the third lecture, *The Patient as a Person,* Dr. G. Canby Robinson describes a study made by him at Johns Hopkins Medical School and Hospital in the department of medicine. The patient was considered as to the disease that might be present, his reaction to the social and environmental conditions related to the illness, and his personality. Of 174 patients studied, 80 per cent revealed some adverse social condition, and in 66 per cent the adverse social condition was related to the illness or to medical care. In 36 per cent of the total number, emotional disturbances were the chief precipi-

tating cause of the illness. This study of the patient as a person is illustrated throughout with case material.

Dr. Franz Alexander contributes the fourth lecture, *Present Trends in Psychiatry and the Future Outlook,* tracing the development of histopathological, bacteriological, and biochemical methods in psychiatry as well as the descriptive psychiatry of Kraepelin. Acknowledging the influence of Charcot, Bernheim, and Liebenault, he ascribes the beginning of the psychodynamic approach to Freud. Nevertheless, it required fifty years for psychoanalytic concepts to be incorporated into medical thinking. Dr. Alexander discusses the old dualistic arguments between constitutional, structural, physiological explanations and psychological explanations. He points out the progressive reconciliation of the psychological and somatic points of view, the present psychosomatic approach. Finally he draws attention to the developments in the field of cultural anthropology and the significance of these to the whole problem of education and the prevention of mental illness.

The fifth lecture, *Psychiatry and the War,* by Dr. William C. Menninger, gives a comprehensive account of the background and development of psychiatric service in the army. Dr. Menninger also shows how this service was organized and describes the use of psychiatrists in the selection of men, in their training and discipline, in the treatment of patients, and in their discharge from the service. He outlines the use of psychiatrists as consultants in the service commands to the theater surgeons in five overseas theaters. He describes the mental-hygiene consultation centers, the hospital organization, and the stages and methods of handling the psychiatric casualties of actual combat. This all-too-brief lecture is as comprehensive and authoritative a statement of the use of psychiatry and psychiatrists by the army as is to be found anywhere.

The last of the series, *Psychotherapy in Everyday Practice,* is by Dr. Edward Weiss. In this lecture Dr. Weiss discusses the need of the general practitioner to utilize the knowledge of psychiatry in the ordinary medical and surgical treatment of patients. Some attention is paid to current medical and surgical practices on patients who are psychoneurotic. Dr. Weiss makes a plea for doing away with the concept of either functional or organic and replacing it with the psychosomatic concept in medicine. He sums up this approach as looking on illness as an aspect of behavior instead of the treatment of disease in ill persons. His point of view is well illustrated with pertinent case material. He points out that the fundamental error of modern medical science has been the divorce of both medicine and surgery from psychiatry.

These six lectures represent a distinct contribution to the "March

of Medicine Series." The Committee on Lectures to Laity of the New York Academy of Medicine are to be congratulated on the choice both of topics and of lecturers for this 1945 series.

JAMES M. CUNNINGHAM.

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A PSYCHIATRIC PRIMER FOR THE VETERAN'S FAMILY AND FRIENDS. By Alexander G. Dumas, M.D., and Grace Keen. Minneapolis: University of Minnesota Press, 1945. 214 p.

This short handbook will be welcomed as a very readable expansion of Rennie and Woodward's pamphlets, *When He Comes Back* and *If He Comes Back Nervous.* It is appropriately called a primer, and it is written in the intimate, conversational style of popular scientific articles. In presenting the psychological problems of veterans on their return to civil life, the book succeeds admirably in its dual purpose of creating an atmosphere of understanding, and in prescribing simple psychiatric first-aid techniques.

The established precepts of mental hygiene are applied in a systematic way to the readjustment problems of the uninjured, the physically injured who need only vocational rehabilitation, the physically injured who need medical and psychiatric treatment, and the mentally and emotionally hurt who need especially considerate care. The book is replete with brief case-history vignettes, and interest is sustained through catchy subtitles and provocative pen drawings which illustrate typical adjustment situations in symbolic form. A number of chapters are followed by concise "Do's and Don'ts," which aim to dispel common misunderstanding and ignorance respecting the mentally and emotionally ill.

Besides its direct practical value in relation to the personal and vocational readjustment problems of veterans, this book helps to give the lay reader an insight into psychosomatic interrelationships, and it also clarifies in simple language the gradation that exists between the various types of mental disorder. The discussion of psychoneurosis is particularly well handled. Proper emphasis is placed on the therapeutic value of a job. The opportunities, as well as the limitations, of help that can be given at home and on the job are presented clearly and succinctly. This book brings the functions of the psychiatrist close to that of the family without either overselling psychiatry or encouraging laymen to assume responsibilities for therapy on the professional level. Emphasis is placed throughout on the teamwork approach between home, work, and professional counsel that is so essential in the management of mental and emotional disturbances.

In addition to its primary purpose as stated in the title, the book serves as an excellent guide for those who seek preparation for counseling work with veterans. Its common-sense approach to individual readjustment problems in the post-war period should extend its usefulness beyond the group for which it was specifically written. It may well be recommended as a rehabilitation guide for many other physically and emotionally handicapped individuals.

L. E. Himler.

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Handbook for Psychiatric Aides. Section I: *A General Guide to Work in Mental Hospitals.* Philadelphia: National Mental Health Foundation, 1946. 58p.

Any one familiar with mental hospitals would say, after reading this little book, that it was well written, interesting, and a most useful and practical book for attendants—or for those who are thinking of becoming attendants—to read. There are, however, other and more significant things to say about it.

It demonstrates that a very extensive subject can be condensed into a simple, short, and dynamic pamphlet without important omissions and without sacrificing scientific truths. By the very fact of its publication and probably large circulation, it shows how rapid an advance is now being made by psychiatry in the practical treatment of the mentally ill. It illustrates how attractive printing and editing can increase the probability of interesting those who might be casually looking at it because some one suggested that they do so.

It suggests, though it does not directly mention the fact, that as the standards and knowledge of attendants increase, this important occupation will become more and more nearly a profession. It implies that when attendants think of themselves as professional people, they will enjoy their work more and be more likely to continue in the field.

Perhaps its greatest usefulness—if it is read as it should be, by every psychiatrist on the staff of every mental hospital—will be to create a feeling of respect and professional relations between physicians and attendants.

The National Mental Health Foundation is to be congratulated on its publication.

Charles A. Zeller.

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Lansing, Michigan.

CLINICAL PASTORAL TRAINING. Edited by Seward Hiltner. New York: Commission of Religion and Health, Federal Council of the Churches of Christ in America, 1945. 176 p.

In the summer of 1944, the National Conference on Clinical Training in Theological Education was held in Pittsburgh, at Western Theological Seminary. This book is an informal report of the proceedings of that conference.

It may be stated at the outset that the report is not well formulated, and that the reader cannot judge to what extent the conference served its purpose. The book contains upwards of thirty papers on the following topics: "Development of the Clinical Training Movement"; "Standards for Clinical Training"; "Vocational Aspects of Clinical Training"; "The Place of Clinical Training in the Theological Curriculum"; "Clinical Training in Relation to Other Education for Pastoral Work"; and "Clinical Training in Relation to Post-War Needs." These papers were written by over twenty persons, and were discussed by still others. The editor's task was one of extreme difficulty; and it is no wonder that he was not able either to eliminate repetition or to bring any unity into the report.

The movement had its beginnings in the early twenties, when Dr. William S. Keller arranged in person to give training in clinical methods to a few theological students. A little later Anton Boisen, then chaplain at Worcester State Hospital, inaugurated the plan of having theological students spend a summer vacation in the employ of that hospital for the study of clinical methods. The movement was at first financed by private contributions, but later received annual grants from the National Council of the Episcopal Church. In 1935, the Cincinnati Summer School took the name of Graduate School of Applied Religion, and later was incorporated as a non-denominational institution.

A special study was made of eighty-nine theological schools, and it was found that about 10 per cent of them are now making some provision for clinical training. This is a fairly good showing in twenty years, for a movement which has never received anything approaching adequate financial support.

The impact of the war has emphasized the urgent need for clinical training. Many chaplains, going into the army with little experience in personal counseling and faced with the responsibility for counseling soldiers, felt completely lost in this important part of their work. Too often they sought to give direction, almost by order, instead of listening sympathetically and aiding the soldier to find his own solution by talking over his problem. On the other hand, some chaplains have seized every opportunity for individual work with soldiers who were in need of guidance. Men returning

from combat areas have had experience with chaplain leadership that has made religion real to them. These soldiers, when they return to civilian life, are going to demand dynamic leadership from their pastors of the future.

In former times the pastor of a rural church in a stable community had close personal contact with his parishioners, and was able to pick up for himself the experience required for ministering to the individual needs of his people. Like the family physician, he made his contribution to the mental health of the community almost without knowing it. But present-day living conditions, with constant shifting of the parish population, are not conducive to a close personal relationship between pastor and parishioner. The pastor of to-day requires special training in clinical methods, to enable him to recognize the individual needs of those who look to him for spiritual guidance.

This movement appears to have made a good beginning, but much remains to be done. There should be other conferences, and it is important that psychiatrists and social workers be given an opportunity to offer their contributions. Although it was a physician and not a clergyman who first saw the potential value to the pastor of clinical training, this conference was exclusively for ordained ministers.

In the expansion of the movement that is sure to come, it is to be hoped that the breaking down of sectarian barriers will be carried still further. Here is a field in which deeply religious men and women of all faiths can afford to disregard their differences, and can find common ground in the service of humanity.

LEO MALETZ.

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Hathorne, Massachusetts.

THE SOCIAL PROBLEMS OF AN INDUSTRIAL CIVILIZATION. By Elton Mayo. Boston: Harvard University, 1945. 150 p.

This modestly sized book makes its most sincere plea for the application of the approach of the physical sciences (Elton Mayo calls them the "successful sciences") to the area of the problems of human relationships. It persistently points out that unless this is done—and soon—we are on our way to chaos. I asked to review it because of a strong suspicion that the author describes work that will later be seen as doing considerably more for the "successful sciences" than they for our psychosocial problems.

There are two parts, of about equal length—*Science and Society* and *The Clinical Approach*. The first chapter is a statement of the problems that arise out of our rapid development from an

established to an adaptive social order. "We have in fact passed beyond that stage of human organization in which effective communication and collaboration were secured by established routines of relationship" over into one in which the emphasis is upon change and adaptability. We have not developed the social skills with which to cope with this; nor have we even placed any emphasis upon the kind of knowledge (knowledge-of-acquaintance, *savoir*) that is required in these studies. Much is said of the students we are turning out in this area—brilliantly able, but unhappy and ineffective. Altogether a dreary picture.

Then Mayo sets up his basic assumption—that it is primary that "an eager human desire for coöperative activity still persists in the ordinary person," and that the true function of state organization is to provide a framework under which the perennial social instincts of man can develop.

In *The Clinical Approach,* the reader, in some awe, alternately turns from the exciting things discovered to the exciting ways in which this was done—and back. Here are chiefly three carefully worked out case studies in industrial problems. As early as 1926, Mayo's group pretty clearly showed that the hypothesis of individual self-interest (through bonuses, and so on) would not hold water, and that their striking results in the improvement of morale and production depended on the transformation of a horde of "solitaires" into a social group.

The second case study (merely summarized) is the well-known Hawthorne experiment. This was perhaps Mayo's first realization of "the importance of working teams and the free participation of such teams in the task and purpose of the organization as it directly affects them in their daily round." I suppose that the most publicized result of that experiment was that of the interview system, which seemed so inevitably to find that "some experience which might be described as one of personal futility is a common incident of industrial organization for work . . . a profound loss of security and certainty in the worker's actual living and in the background of his thinking."

It was somewhere in these years—as he was seeing more clearly that "teams" are natural and spontaneous developments in an established social order and that an adaptive society inhibits their growth or breaks them up—that Mayo saw the connection between his findings and Chester Barnard's insights into the nature of authority and leadership. This concept of authority is really a ready expression for a "communication link" and the person who exercises authority is that one who is placed at an important point in the line of communication—he is a facilitator of communication.

The third case study—again a summary of what I feel is one of the brilliant and penetrating pieces of work of our time—deals with labor turnover and absenteeism in California during the war. The frustration (in an industrial civilization) of our eager human desire for coöperative activity; the prohibition of the natural formation of group routines in such a civilization; the discovery of groups in the California study formed spontaneously and by chance; the almost magical effect of these in doing away with turnover and absenteeism; the discovery of mechanisms of leadership (only now we will call these "mechanisms of facile communication") in three different types of such groups—here are insights of unmatched importance in the field of mental hygiene in industry.

We have a long way to go, and if we don't hurry, the present "breaking down into [artificial] groups that show an ever-increasing hostility to each other" will overwhelm us. But I prefer to state this as W. B. Donham does in his Foreword: "Mayo shows us for the first time in the form of specific instances that it is within the power of industrial administrators to create within industry itself a partially effective substitute for the old stabilizing effect of the neighborhood." If we understand the needs and will *plan* to meet them, we can build these natural group routines in industrial settings.

In the early pages Mayo discusses briefly knowledge-about and knowledge-of-acquaintance. He is chary in defining the latter—and, indeed, through some of the book mistakes it for first-hand knowledge. This is unfortunate because the great contribution that he and his group will make to all science (even to the "successful" sciences) is precisely this ability to discover and work with knowledge-of-acquaintance. This is the knowledge of direction and relationship rather than of position; of meaning rather than of existence. Mayo knows as well as any one how cluttered the physical sciences are with knowledge-about; that what he means by "successful sciences" is some "successful scientists"; that the solid brilliance of achievement in the physical sciences is the solid brilliance of the Christmas tree's ornaments—existing chiefly in the immaturity of the onlooker. I suppose that this is not the place to dispute the blinding show of the physical sciences; but I can at least say that the way that Mayo looks at data has begun to appear in the physical sciences and will be some day the way that all science will view its material—the way of the "successful scientist."

No book is perfect. This one gets caught up in its enthusiasms, so that while its general organization is admirable, you find yourself running up this or that interesting byway before you know it. Nor can I refrain from reminding an author who has discovered that

labor agitators and leftists are unhappy and unwell people that I know an occasional dyspeptic capitalist.

But these little flaws really only serve to emphasize the solid importance of a magnificent life's work.

JAMES S. PLANT.

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ABRIDGED LECTURES OF THE FIRST (1943) SUMMER COURSE ON ALCOHOL STUDIES AT YALE UNIVERSITY. New Haven, Conn.: *Quarterly Journal of Studies on Alcohol,* 1944. 109 p.

The growing interest in alcoholism, as an important social and medical problem, is attested by the formation throughout the country of organizations to study it, to teach what is known about it, to treat alcoholics, and to devise means to lessen the social and individual distress that alcoholism causes. One of the most important of these organizations is the Section on Alcohol Studies of the Laboratory of Applied Physiology, Yale University.

The Section on Alcohol Studies gives a summer course of lectures to social workers, teachers, peace officers, ministers, physicians, and others who may be interested. The lecturers are chosen because of their special knowledge of particular phases of the alcohol problem.

The present book is an abridgment of nineteen lectures given by fourteen lecturers at the first summer school in 1943. It covers such aspects of alcohol as anthropology, physiology, nutrition, heredity, mental disease, delinquency, education, treatment of alcohol addiction, contributions of lay therapists, the minister's relation to the alcoholic, state laws on the control of alcoholic-beverage trade, and so on.

The abridgement has been done in such a way as to bring out in an easily readable form the salient points of each lecture without burdening the reader with too much detail. The book is recommended to the interested public as a source of much valuable information.

LAWRENCE KOLB.

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Sacramento, California.

A GUIDE ON ALCOHOLISM FOR SOCIAL WORKERS. By Robert V. Seliger, M.D. New York: The William-Frederick Press, 1945. 94 p.

This book is a collection of papers by Dr. Seliger on various phases of alcoholism. It has seven chapters, one of them a sort of introduction. Four of them contain worth-while information about alcoholism and advice to alcoholics and workers in the alcohol field. Two

of them—*The Rôle of Psychiatry in Alcoholism* and *Social Pathology in Contemporary Alcoholism in America*—are repetitious. They also contain material that is likely either to confuse the thinking of the uninitiated or lead him in revulsion to believe that nothing is known about the social causes of alcoholism.

In these chapters the author lists numerous factors in our culture that he considers to be "important and integral in the genesis of contemporary alcoholism." Among these are the following:

"Political 'rationalistic' concepts of democracy, which resulted in the false belief that all men were, being created equal, equally endowed—not in terms of differentiation, but in terms of the same"; capitalism; the premature expansion and industrialization of our country; the emancipation of women; overeducation; seven-dollar dinners, while children in the next city block sleep five to a bed without supper; the can-opener; the automobile; the radio; the movies; and so on.

Some of these factors are discussed, but no attempt is made to explain away or weigh the fact that alcoholism is much less prevalent than it was before the industrial age came on and before the can-opener and the movies were invented.

For the numerous cultural difficulties, the author would "produce a culture that will not develop a pre-alcoholic personality." He is not specific about what he would do, but we doubt whether he would abolish the movies and the radio or whether he could regulate them better than they are being regulated. One is reminded here of a statement by Thomas Jefferson that the Virginian of his day spent his time talking politics, avoiding work, and drinking whisky. One cannot but believe that with the recreational and cultural outlets we now have—outlets made possible by the industrial expansion that the author indicts—the Virginians of Jefferson's day would have drunk less whisky.

In spite of the digression of these two chapters into phantasy or mere words, one of them contains practical, common-sense suggestions about the alcohol problem.

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COÖPERATION IN CRIME CONTROL. Edited by Marjorie Bell. (Yearbook of the National Probation Association, 1944.) New York: The National Probation Association, 1945. 320 p.

This is a collection of papers presented at the Thirty-eighth Annual Conference of the National Probation Association, in Cleveland, Ohio, May, 1944, augmented by a survey on federal and state legislation and

court decisions affecting juvenile courts, probation, and parole during the year 1944.

It is significant that more than two-thirds of the articles in this book deal with the problems of youth in general and the youthful offender in particular, thus obviously answering a need for clarification of the juvenile-delinquency situation which has gained so much publicity during the war years. Another characteristic feature, which comes to the fore in a great number of the papers and which is also expressed in the title of the book, is the emphasis laid upon coöperation between the various agencies that deal directly or indirectly with the control of crime and delinquency, and the inclusion of the community at large in this field of endeavor.

As in previous yearbooks of the National Probation Association, the most fundamental paper is contributed by the president of the association, Dr. Roscoe Pound, Dean Emeritus, Harvard Law School. In his article, *The Juvenile Court and the Law,* Dean Pound relates juvenile-court legislation, jurisdiction, and administration to the general function of the law—namely, that of finding the proper balance between justice (the ideal relation between men), morals (the development of the individual as to behavior), and security (the immediate province of the legal order). He traces the juvenile court back to its inception in 1899 in Illinois, and calls it fortunate that "it was set up as a court of equity, with the administrative functions incidental to equity jurisdiction, not as a criminal court, and not, as might have happened later, as an administrative agency with incidental adjudicating functions." He quotes the five characteristics of equity procedure that are also characteristic of juvenile-court procedure: it is relatively informal; it is remedial, not punitive; it acts preventively; it employs administrative methods (especially through the medium of probation); and it achieves a high degree of individualization.

"Speaking as one judge to another," Judge Paul W. Alexander, of the Domestic Relations and Juvenile Court, Toledo, Ohio, addressing the National Council of Juvenile Court Judges (which met with the National Probation Association), points out that the curse of the juvenile court is politics. By that, he does not mean political influence upon the judicial decisions of the juvenile-court judge—of which, he says, he has "never yet heard a single breath of suspicion"—but the playing of politics by the judge in appointing his professional staff. He calls upon the judges themselves to stand up against the principle of political patronage as regards juvenile-court positions, and to win the approval of the community by doing a good job with a qualified non-political staff, since "playing politics with children will not be tolerated by enlightened citizens."

The rôle of the school is discussed by Robert C. Taber, Director of the Division of Pupil Personnel and Counseling, Philadelphia Board of Public Education, in his paper, *The Judge and the Schools,* and by Frank O'Brien, M.D., Associate Superintendent of the Board of Education, New York City, in an article entitled *Social Services in Education.* Both stress the shift of emphasis from purely intellectual achievement as the purpose of public education to a philosophy of preparing children for life and living. Mr. Taber elaborates on the expanded counseling service in the Philadelphia schools and the close coöperation between the board of education and the juvenile division of the municipal court. Dr. O'Brien emphasizes that the teacher must consider himself as a member of a team that includes the parents, clergy, court officers, and medical, social, and recreational workers.

The particular problem of the delinquent girl is the topic of two papers—*Protective Police Services,* by Rhoda J. Milliken, Director of the Women's Bureau, Metropolitan Police Department, Washington, D. C., which deals with the various functions of women police officers; and *Girls Are Different,* by Mary Edna McChristie, Referee of the Girls' Division, Court of Domestic Relations, Cincinnati, Ohio. Miss McChristie lists the various types of sex delinquent, not from a legal, but from a psychological point of view. She pays tribute to the local social-hygiene society, "whose woman consultant educates the uninformed and tries to change the distorted ideas of the misinformed; even the highly promiscuous sex offender can benefit from this contact and learn to give the sex relationship a wholesome interpretation."

In his paper, *The Juvenile Delinquent Meets Case-Work,* Clinton W. Areson, Superintendent of the State Agricultural and Industrial School, Industry, N. Y., cautions against the "case-worked boy" and the "trained clients" who, after various contacts with professional workers, give all the answers that they think are expected from them. He stresses the need for continuity of case-work through the various phases through which a juvenile delinquent may pass—*i.e.,* investigation, probation, training school, parole. The same idea in regard to the adult offender is underscored by Kenneth L. M. Pray, Director of the Pennsylvania School of Social Work, Philadelphia, who discusses "Parole in Relation to Classification and Case-Work in Prison." Mr. Pray sees parole service and the practice of social case-work as coming closer and closer together, since both are based on the premise that the individual must "accept responsibility for the choice he does and must make."

In *Treatment without Conviction,* Philip Heimlich, Director of the Youth Counsel Bureau, the District Attorney's Office, New York City, describes the work of this agency, particularly for the adolescent offender who for technical reasons might have been discharged by

criminal courts and the grand jury, but who is in need of help and guidance.

Austin L. Porterfield, professor of sociology at Texas Christian University, in his paper, *Parents and Other Complainants in the Juvenile Court,* proposes that, instead of smugly blaming the parents for their children's misbehavior, we should rather recognize that "parents, too, have problems because they, too, are people" and that they "need help (1) with human nature, (2) with their own childhood, (3) with one another, (4) with their children, (5) with and from the community." This mode of approach is also stressed by Genevieve Gabower, of the Children's Bureau, U. S. Department of Labor, in her contribution, *Community Action to Deal with Juvenile Delinquency.*

Special war-time problems are aired by Mark A. McCloskey, Director, Community War Services, Federal Security Agency, in his paper, *War-time Delinquency and the Job Ahead;* by Russell Jackson, Coördinator of Community Activities, Phoenix, Arizona, in *The Home Front Against Juvenile Delinquency;* by Richard L. Jenkins, M.D., Acting Superintendent, Institute for Juvenile Research, Chicago, in *Factors Influencing War-time Increase in Juvenile Delinquency;* and, in the adult field, by Richard E. Cohn, Employment Director, New York State Division of Parole, in *War-time Acceptability of Probationers and Parolees for Employment.* It is in these papers, particularly, that reference is made to the participation of the citizenry as a whole, including the young people themselves, in the field of positive community action aainst crime and delinquency.

Frank W. Haggerty, a member of the Board of Prison Terms and Paroles, Olympia, Washington, in *Classification Preparatory to Greater Parole Success,* states that "classification is not of itself a program of rehabilitation" and demands more and better therapeutic clinics in and outside penal and correctional institutions.

Ralph S. Banay, M.D., Associate Director of the Research on Crime and Delinquency, Columbia University, in *Therapeutic Experiences with Adult Offenders,* deals particularly with the psychopathic personality ("The psychopaths all indicate an impaired reality sense and inability to telescope themselves into the full complexities and significance of the accepted standards of human existence") and the often disguised cases of psychomotor epilepsy which he describes as "convulsions of emotion" (as distinguished from physical convulsions).

One of the high lights of the book is Seldon D. Bacon's *Alcoholism and Social Isolation.* As a sociologist (he is assistant professor of sociology at Yale University) he describes the forms and functions of the "primary group" (child play group, family, friendship), with

its characteristics of intimacy, frequent contact, informality, mutual give and take, limitation as to numbers possessing similar traits, and a broad range of reciprocal interests. To be integrated into such a group is most difficult for the alcoholic. The author praises "Alcoholics Anonymous" for having provided the primary-group atmosphere and attributes their success to this feature.

The officers of the National Probation Association are to be commended for the ability with which they have brought together the contributions of a most representative group of theorists and practitioners in the correctional field.

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THE MARIHUANA PROBLEM IN THE CITY OF NEW YORK. By the Mayor's Committee on Marihuana, with a Foreword by Mayor LaGuardia. Lancaster, Pennsylvania: The Jaques Cattell Press, 1944. 220 p.

As explained by Mayor LaGuardia in the foreword to this volume, he appointed a committee to study the marihuana problem in New York on the advice of The New York Academy of Medicine. Rumors had previously reached him of the smoking of marihuana by large groups of citizens, including many school children. The committee chosen consisted of a distinguished group of New York physicians, with George B. Wallace, M.D., as chairman and E. H. L. Corwin, Ph.D., as secretary, and with four New York City commissioners as *ex officio* members.

The funds required for the study were provided by three donations of $7,500 each made by the Friedsam Foundation, the New York Foundation, and the Commonwealth Fund.

The general study was made in three parts, as follows:

I. The sociological study, made by six police officers under the direction of Dr. Dudley D. Schoenfeld.
II. The clinical study, consisting of two divisions: the medical, including the psychiatric, and the psychological. The former division was directed by Dr. Karl M. Bowman and the latter by Dr. David Wechsler.
III. The pharmacological study, made in the Department of Pharmacology of Cornell Medical School by Drs. S. Loewe and W. Modell.

The committee made a thorough study of the distribution and use of marihuana in various sections of New York. Its representatives visited the so-called "tea-pads" where marihuana smokers congregate, and formed the acquaintance of a considerable number of the smokers. They also visited public schools and conferred with school principals and teachers. Likewise they made contact with the

city courts with a view to learning the influence of marihuana smoking on juvenile delinquency. At the conclusion of the study the committee reached important conclusions as follows:

> "Marihuana is used extensively in the Borough of Manhattan, but the problem is not as acute as it is reported to be in other sections of the United States.
>
> "The distribution and use of marihuana is centered in Harlem.
>
> "The majority of marihuana smokers are Negroes and Latin-Americans.
>
> "The practice of smoking marihuana does not lead to addiction in the medical sense of the word.
>
> "The use of marihuana does not lead to morphine or heroin or cocaine addiction and no effort is made to create a market for these narcotics by stimulating the practice of marihuana smoking.
>
> "Marihuana is not the determining factor in the commission of major crimes.
>
> "Marihuana smoking is not widespread among school children.
>
> "Juvenile delinquency is not associated with the practice of smoking marihuana."

The clinical studies were carried out at Welfare Hospital, later named the Goldwater Memorial Hospital. They were made by thorough observation of the effects of marihuana on 77 subjects. The drug was smoked in cigarettes or taken by mouth in the form of an extract. The effects on attitude and behavior and on the functioning of all the organs of the body were recorded. In nine subjects a psychotic episode of short duration occurred. In general it was found that a mixture of euphoria and apprehension was present, although the symptoms varied with the amount of the drug taken. No permanent damage to the subject was observed and it appeared that the drug was not habit-forming.

The book gives in great detail the results of the psychiatric and psychological study and contains an interesting chapter on the pharmacology of the drug.

The study as a whole is to be highly commended for its comprehensive presentation of facts on the effects of marihuana, and its readers will be gratified to learn that the problem is not as serious as was previously believed.

HORATIO M. POLLOCK.

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THE INFLUENCE OF PARENTAL ATTITUDES AND SOCIAL ENVIRONMENT ON THE PERSONALITY DEVELOPMENT OF THE ADOLESCENT BLIND. By Vita Stein Sommers. New York: American Foundation for the Blind, 1944. 124 p.

It has long been imagined, in accordance with the Adlerian theory of organ inferiority, (1) that the blind must exhibit a high incidence of personality maladjustments, and (2) that these malad-

justments are traceable to the physical fact of blindness. There never has been any respectable research confirming either of these generalizations for any handicapped group, much less for the blind. On the contrary, the available studies contrasting normal and handicapped, seeing and blind, are noteworthy for the absence of differences, for sex differences in opposite directions, and for the large amount of overlap in the scores of contrasted groups.

In opposition to Adlerian theory, many have urged on general principles that the maladjustments shown by the individual with a handicap are derived not so much from the physical fact of the handicap as from the psychological fact of being treated as a handicapped person. Dr. Sommer's volume is addressed to the demonstration of this highly important distinction.

Omitting consideration of two supplementary studies, the main body of Dr. Sommer's study is devoted to the analysis of intensive interviews, case studies, and quantitative ratings on fifty blind children and their social environments, with special reference to parental attitudes. This material is introduced in Chapter V by a brief statement of the psychological effects on parents of blindness in their children. Chapter VI presents five case studies illustrating five types of parental adjustment: acceptance of the handicap, denial of the handicap, overprotectiveness, disguised rejection, and overt rejection.

Blindness arouses such intense parental reactions that these five case studies alone, plus general mental-hygiene principles, should be thoroughly convincing of Dr. Sommer's thesis. Chapter VII presents in turn eleven case studies, illustrating five types of adjustive behavior by blind children which make it unmistakably clear that it is the whole social environment and especially parental attitudes, rather than the physical fact of blindness, that determine individual mechanisms of adjustment in the blind child.

To clinch the matter, Dr. Sommers had three persons read the fifty case studies and independently rate the social environment on seven scales and the children's personality adjustment on five scales. The intercorrelations of these twelve variables amply confirm the interpretations based on the case studies. The statistical data, incidentally, are of considerable interest for their illustration of how case-study materials may be quantitatively analyzed.

Dr. Sommer's study is not merely an important contribution to the psychology of the blind. It is an important contribution to the psychology of personality development.

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PLAINVILLE, U.S.A. By James West. New York: Columbia University Press, 1945. 238 p.

Now that every one is prattling with great fluency and complacency about "our American way of life," and there is great pressure for the reëducation of large areas of the world along similar lines, it is an interesting experience to read such a book as *Plainville, U.S.A.*, by James West, an anthropologist, who focused his scientific methods on a typical trading center of 1,000 population, in a farming community in the southern Mid-West area of the country. For more than a year, the author lived in the community and analyzed its life with anthropological techniques, usually reserved for the study of primitive cultures in romantically remote corners of the globe. The book leaves one with the impression that the life of this typical American community is singularly drab, monotonous, and uninspiring, and that some of our free-floating missionary zeal and available funds might well be expended on the stimulation of a more creative, æsthetic, and emotionally satisfying type of culture in our own home-town communities.

In the first chapter, the geography, history, and natural resources of the community are presented; housing, clothing, and communications are described; and occupations, means of subsistance, and technology are analyzed. The availability of manufactured equipment, the introduction of the automobile and telephone, and the development of roads and railway connections have wrought great changes in the life of this community.

Chapters two and three describe the social structures functioning in the community, including the life of families and neighborhoods; the educational, social, and political organizations; the means of maintaining law and order; and the stratification of the population in a hierarchy of about five social classes, ranging from the "upper crust" down to those elements in the population "who live like animals." Although all are theoretically convinced that they live in a classless society, as a matter of fact, every individual, family, or organization is classified according to relative rank in the social and financial class structure of the community. "Even the churches are arranged in a strict hierarchy of class." Training in class distinctions and class behavior patterns is "gradually implanted" in the minds of children in their homes. Although all proudly declare that "anybody can rise," the fact remains that the "two main classes are rigidly exclusive systems into which people are born" and "movement across the line separating the upper class from the lower class is virtually impossible, without leaving the community."

In Chapter IV, on "Religion," the author states that from "a

fourth to a third of the people" may perhaps be classed as "non-believers," although some attend church as a matter of policy or as testimony of good citizenship, or because there is nowhere else to go. One or more revivals each year are still held in all the churches, with emphasis on saving the souls of the unconverted. Only in the most emotional and socially "lowest" religious groups does religion seem to have any effect on the daily life of church members. Theirs is a "strictly seven-day-a-week" religion, and only in this congregation is found "mutual helpfulness in exchanging work and food and the practice of material charity for the poor." Religious control of morals "operates mainly through gossip and the fear of gossip," and in none of the churches "are discussed any of the important problems of agriculture, ethics, and human relationships that actually face the community." The churches are regarded by the few progressives or reformers as opposing science, preventing all progress, and as being merely a "social center, especially for women." Even a retired preacher said, "The Church does nothing. It's bound to formula. . . . It's just an insurance policy for the old, and a gossip center."

Because diet and sanitation are poor, there is a high incidence of rickets and tuberculosis among children. Almost 85 per cent of the children in the county are enrolled in school and half of those eligible now go to high school. A minority attend school with great irregularity. Although the state sets up educational aims and provides a standard state course of study, deviations are great and each teacher seems to teach what she pleases. Because "few teachers dare to fail a child," some are graduated from high school without having learned to read with facility. With the exception of music and vocational agriculture, the courses in high school are poorly taught by poorly prepared teachers. Vocational agriculture is "the only subject in the high-school curriculum which in content and instructional method is completely appropriate functionally to the community—and it is the only subject which a large portion of the community opposes and ridicules."

Because employment opportunities are very limited in the area, where average, regular jobs pay only $30 to $50 per month, about half the young people of each generation migrate elsewhere to urban communities. Without any special vocational, economic, or social training for anything else, they are usually employed there at hard, unskilled labor. As the chief aim of the educators is "to give my patrons exactly the kind of a school that they want," there is little opportunity for any vital or critical thinking or for any innovations in social, cultural, or vocational activities to seep into the

community. "Nothing can be taught in school because the religious people would rise up in wrath," and the school "tries to serve the whole community" without offending anybody.

The old lodges are dying out, the towns are too poor to support service clubs, and the two small community projects sponsored by a short-lived Progressive Club both failed. Four-H and Boy Scout troops wither and die. Entertainment and recreational programs and other community activities of a social nature are resisted and ridiculed. The social integration of the community as a whole "rests on the easy intimacy of men" and "the community *is* a community because men can associate freely beyond the walls of their homes."

Family life and relationships are discussed in Chapter V, entitled *From Cradle to Grave.* The author states that "families of six to twelve children, commonplace only forty or fifty years ago, are now rare, even among the lower class." Such large families are "both ridiculed and condemned, and are attributed to selfishness, laziness, or carelessness on the part of the husband, or, in some very religious lower-class families, to an 'old-fashioned' idea that children are the gift of God, whose will should not be interfered with." Any discussion of "sexual" subjects is considered "delicate and embarrassing," unless "couched lightheartedly in a special and obscene 'male' vocabulary." Sexual relations between husband and wife "are said to be usually unsatisfactory" and the common belief is "that the majority of women are frigid." There is a "widespread feminine attitude that sex is predominantly a male interest—something that girls should be warned against, though taught to accept as a later wifely duty; an interest which women are tacitly banded together to resist as strongly as they dare." These attitudes, so destructive to any emotionally satisfying family relations, are the result of completely ignoring the need for the wholesome sex education of children. "Sex is a subject which neither mothers nor fathers feel they can discuss with their children." Fathers, especially, seem incapable of giving any instruction or guidance to their sons, and this constraint usually continues until after the son is married and has children of his own.

From earliest years, two very different patterns are inculcated in the boys and in the girls. The traits of cleanliness, modesty, passivity, and submissiveness are encouraged in the girls, who learn the womanly activities of homemaking and one or two of the most elementary "facts of life" from their mothers. The boys, on the other hand, are encouraged to be aggressive, combative, and dominating, to feel superior to females, and to have "contempt for the work, interests and intelligence of girls and women." Left to them-

selves in their age-group gangs, they learn, in addition to useful boyhood skills, a "great number of 'dangerous' and 'outlaw' traits." These include a scorn for bathing and cleanliness, pleasure in breaking and destroying, the teasing and torturing of girls and smaller boys and cruelty to any form of life, swearing and stealing, and the ability to talk "dirty" and to tell "dirty stories."

Between the ages of ten and twelve, boys are taught by slightly older boys to perform their first sexual experiments with other boys, domestic animals, and occasionally with little girls. At seventeen or eighteen, they are expected to experiment with drinking, "running around," and "sowing wild oats" with prostitutes or lower-class girls, without, however, "acquiring any fixed bad habits." Without any instruction, the boys are, at the same time, supposed to use enough "sense" and secrecy to avoid gossip, scandal, and "trouble" in the form of infection with venereal diseases or unwanted pregnancies, which will be costly to their families or may result in forced "unfortunate" marriages. Any boy who does not conform to these destructive patterns is regarded as a "sissy." Much of the frigidity of the women is no doubt due to the coarseness and crudities of sexual approach that such a background would engender.

No boy without the use of a car can hope for a date and in high school the majority of both sexes have no dates. Although about 50 per cent of the most mature boys compete for about 10 per cent of the most popular girls, in some manner unknown, almost no one in the community fails to get married. This appalling and tragic neglect of educating, training, guiding, and helping children to acquire an understanding of the most basic aspects of human life cannot but be contributory to a great volume of varied types of social pathology.

The author has made a valuable contribution to the available literature on community studies and this book should be widely read by all those interested in a realistic portrait of an American community and in a sample of the quality of life in a typical small community in the United States.

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OUR INNER CONFLICTS. By Karen Horney, M.D. New York: W. W. Norton and Company, 1945. 250 p.

In this presentation more than in her other books, the author has focused her material around the interpersonal relations of her patients. The discernment and richness of detail with which this is done represent a substantial contribution to the literature.

Dr. Horney then proceeds to explain her own theoretical position, "I see the basic conflict of the neurotic in the fundamentally contradictory attitudes he has acquired towards other persons." This Dr. Horney refers to as "the nucleus of a new theory of neurosis."

As the result of the child's feelings "of being isolated and helpless in a potentially hostile world," she views the child as moving "towards people," "against people," or "away from people." This leads to her dividing individuals into three groups, in which one or another of the following types of behavior predominate: Group I, The Compliant Type ("Moving Towards People"); Group II, The Aggressive Type ("Moving Against People"); Group III, The Detached Type ("Moving Away from People").

The author's chapters on these three types of behavior are well presented, as are her chapters on "The Idealized Image," "Externalization," "Impoverishment of Personality," and "Sadistic Trends."

Those who are thoroughly familiar with the psychoanalytic literature will recognize the special point of view presented and will note the absence of statements of theory which are needed if one is to relate the interpersonal relations of man to their origins in biological structure and function. This book can be highly recommended to psychiatrists, social workers, or any other professional or lay reader who is seriously interested in human interpersonal relations.

E. Van Norman Emery.

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The Dice of Destiny; An Introduction to Human Heredity and Racial Variations. By David C. Rife. Columbus, Ohio: Long's College Book Company, 1945. 163 p.

The creditable purpose of this book, whose author is associate professor of zoölogy at Ohio State University, is stated in a brief introduction which clearly formulates the general principles of what is called the "politico-genetic" aspects of human welfare. Emphasis is placed on the biological significance of normal and relatively common racial variations rather than on any specialized problems of medical genetics as concerned with more unusual abnormal differences among individuals. The author's main objective is the promotion of general interest in the intricate interactions of heredity and environment in the production of racial differences and their socio-economic implications. In plain language and with unquestionable sincerity, a better understanding of our fellow men is stressed as indispensable for the maintenance of world peace and for the establishment of a truly democratic brotherhood of man.

The first chapters of the relatively small volume deal with the elementary principles of human heredity. Explicit topics such as taste and blood variations are selected to explain the mechanism of gene behavior, without recourse to complicated symbols or antiquated patterns of demonstration.

The major part of the book is devoted to a description of common human traits which owe their variations to an interaction of heredity and environmental factors. A critical analysis of sex differentiation, twinning, handedness, intelligence, and special abilities leads to a discussion of the most difficult genetic subjects bearing on personality development, adaptation, and survival.

In the last chapter, *Genes and Democracy,* the author cautions against both racial intolerance and unsound disregard of racial differences. On scientific grounds, there can hardly be any objection to his warning that "we must not allow our zeal in overthrowing the erroneous ideas of race superiority to cause us to err too far to the other extreme."

Despite the selection of a somewhat dramatic and possibly misleading title, the author never lets one forget that he is an experienced and conscientious scholar of human heredity, who is searching for the truth. He spares no efforts in an attempt to take an objective, middle-of-the-road position in the presentation of complex biological problems related to the ancient nature-nurture controversy. His arguments are largely restricted to available facts, his conclusions are guarded and constructive, and his style of writing is precise, simple, and usually on the side of understatement. Whenever technical terms are used, they are so clearly defined that their meaning should be easily comprehensible to any intelligent reader.

Except for a rather excessive share of typographical errors, the volume is adequately printed and well illustrated. It certainly is handy and contains a wealth of factual material. There is little doubt in the reviewer's mind that this book will prove to be both a source of stimulation and a mine of information to every one interested in the problems of public welfare and mental hygiene.

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NOTES AND COMMENTS

National Mental Health Act * as Passed by Congress

We present below the exact wording of the National Mental Health Act as passed by Congress and signed by the President. This act is in the form of an amendment to the Public Health Service Act, Public Law 410—78th Congress. Its interpretation is in part dependent upon the committee reports. Therefore Public Law 410 and the House of Representatives Report 1445—79th Congress on H.R. 4512 and Senate Report 1353—79th Congress on H.R. 4512 should be taken into account in considering the act. These reports, as well as a copy of the act, can be secured through your Congressman.

[Public Law 487—79th Congress]

[Chapter 538—2d Session]

[H. R. 4512]

AN ACT

To amend the Public Health Service Act to provide for research relating to psychiatric disorders and to aid in the development of more effective methods of prevention, diagnosis, and treatment of such disorders, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "National Mental Health Act."

PURPOSE

Sec. 2. The purpose of this Act is the improvement of the mental health of the people of the United States through the conducting of researches, investigations, experiments, and demonstrations relating to the cause, diagnosis, and treatment of psychiatric disorders; assisting and fostering such research activities by public and private agencies, and promoting the coördination of all such researches and activities and the useful application of their results; training personnel in matters relating to mental health; and developing, and assisting States in the use of, the most effective methods of prevention, diagnosis, and treatment of psychiatric disorders.

DEFINITIONS

Sec. 3. (a) Section 2 of the Public Health Service Act (42 U. S. C., ch. 6A) is amended by striking out the word "and" at the end of para-

* In the item in the July issue of Mental Hygiene presenting excerpts from the Congressional debate on this act as a bill, it was incorrectly referred to as the National Research Institute Bill. The establishment of a research institute is only one of the provisions of this act.

graph (j), by striking out the period at the end of paragraph (k) and inserting in lieu thereof a semicolon, and by inserting after paragraph (k) the following new paragraphs:

"(l) The term 'psychiatric disorders' includes diseases of the nervous system which affect mental health; and

"(m) The term 'State mental health authority' means the State health authority, except that, in the case of any State in which there is a single State agency, other than the State health authority, charged with responsibility for administering the mental health program of the State, it means such other State agency."

SEC. 4. Section 208(b) of the Public Health Service Act is amended to read as follows:

"(b) (1) Whenever commissioned officers of the Service are not available for the performance of permanent duties requiring highly specialized training and experience in special fields related to public health, the Administrator on recommendation of the Surgeon General shall report that fact to the President and the President is authorized to appoint, by and with the advice and consent of the Senate, not to exceed three persons in any one fiscal year to grades in the Regular Corps of the Service above that of senior assistant, but not to a grade above that of director.

"(2) Officers may be appointed to grades in the Regular Corps of the Service above that of senior assistant, but not to a grade above that of director, to assist in carrying out the purposes of this Act with respect to mental health, but not more than twenty such officers appointed pursuant to this paragraph shall hold office at the same time.

"(3) For purposes of pay and pay period any person appointed under the provisions of this subsection shall be considered as having had on the date of appointment service equal to that of the junior officer of the grade to which appointed."

NATIONAL ADVISORY MENTAL HEALTH COUNCIL

SEC. 5. (a) Subsection (e) of section 209 of the Public Health Service Act is amended to read as follows:

"(e) Members of the National Advisory Health Council, members of the National Advisory Mental Health Council, and members of the National Advisory Cancer Council, other than ex officio members, while attending conferences or meetings of their respective Councils or while otherwise serving at the request of the Surgeon General, shall be entitled to receive compensation at a rate to be fixed by the Administrator, but not exceeding $25 per diem, and shall also be entitled to receive an allowance for actual and necessary traveling and subsistence expenses while so serving away from their places of residence."

(b) The title of section 217 of such Act is amended to read "National Advisory Health, Cancer, and Mental Health Councils."

(c) Subsection (b) of section 217 of such Act is amended to read as follows:

"(b) The National Advisory Health Council shall advise, consult with, and make recommendations to, the Surgeon General on matters relating to health activities and functions of the Service. The Surgeon General is authorized to utilize the services of any member or members of the Council, and where appropriate, any member or members of the

National Advisory Cancer Council or of the National Advisory Mental Health Council, in connection with matters related to the work of the Service, for such periods, in addition to conference periods, as he may determine."

(d) Section 217 of such Act is further amended by adding at the end thereof the following new subsections:

"(d) The National Advisory Mental Health Council shall consist of the Surgeon General, ex officio, who shall be chairman, and six members to be appointed without regard to the civil-service laws by the Surgeon General with the approval of the Administrator. The six appointed members shall be selected from leading medical or scientific authorities who are outstanding in the study, diagnosis, or treatment of psychiatric disorders. Each appointed member shall hold office for a term of three years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the first terms of the original appointed members shall expire, as designated by the Surgeon General at the time of appointment, two at the end of one year, two at the end of two years, and two at the end of three years. An appointed member shall not be eligible to serve continuously for more than three years but shall be eligible for reappointment if he has not served immediately preceding his reappointment.

"(e) The National Advisory Mental Health Council shall advise, consult with, and make recommendations to, the Surgeon General on matters relating to the activities and functions of the Service in the field of mental health. The Council is authorized (1) to review research projects or programs submitted to or initiated by it in the field of mental health and recommend to the Surgeon General, for prosecution under this Act, any such projects which it believes show promise of making valuable contributions to human knowledge with respect to the cause, prevention, or methods of diagnosis and treatment of psychiatric disorders; and (2) to collect information as to studies being carried on in the field of mental health and, with the approval of the Surgeon General, make available such information through the appropriate publications for the benefit of health and welfare agencies or organizations (public or private), physicians, or any other scientists, and for the information of the general public. The Council is also authorized to recommend to the Surgeon General, for acceptance pursuant to section 501 of this Act, conditional gifts for work in the field of mental health; and the Surgeon General shall recommend acceptance of any such gifts only after consultation with the Council."

DETAIL OF PERSONNEL

SEC. 6. Subsection (b) of section 214 of the Public Health Service Act is amended to read as follows:

"(b) Upon the request of any State health authority or, in the case of work relating to mental health, any State mental health authority, personnel of the Service may be detailed by the Surgeon General for the purpose of assisting such State or a political subdivision thereof in work related to the functions of the Service."

RESEARCH, INVESTIGATIONS, AND TRAINING

SEC. 7. (a) Paragraph (d) of section 301 of the Public Health Service Act is amended to read as follows:

"(d) Make grants in aid to universities, hospitals, laboratories, and other public or private institutions, and to individuals for such research projects as are recommended by the National Advisory Health Council, or, with respect to cancer, recommended by the National Advisory Cancer Council, or, with respect to mental health, recommended by the National Advisory Mental Health Council;".

(b) Paragraph (g) of such section is amended to read as follows:

"(g) Adopt, upon recommendation of the National Advisory Health Council, or, with respect to cancer, upon recommendation of the National Advisory Cancer Council, or, with respect to mental health, upon recommendation of the National Advisory Mental Health Council, such additional means as he deems necessary or appropriate to carry out the purposes of this section."

(c) Part A of title III of the Public Health Service Act is further amended by adding at the end thereof the following new section:

"MENTAL HEALTH

"SEC. 303. In carrying out the purposes of section 301 with respect to mental health, the Surgeon General is authorized—

"(a) For purposes of study, to admit and treat at the National Institute of Mental Health, voluntary patients, whether or not otherwise eligible for such treatment by the Service, and patients of Saint Elizabeths Hospital transferred from the hospital pursuant to arrangements made between the Surgeon General and the Superintendent of the hospital with the approval of the Administrator: *Provided*, That consent of a legal guardian shall be obtained before the transfer of any patient from Saint Elizabeths Hospital for such treatment.

"(b) (1) To provide training and instruction, in matters relating to psychiatric disorders, to persons found by him to have proper qualifications, and to fix and pay to any of such persons as he may designate a per diem allowance during such training and instruction of not to exceed $10, the number of such persons receiving such training and instruction to be fixed by the National Advisory Mental Health Council; and (2) to provide such training and instruction, and demonstrations, through grants, upon recommendation of the National Advisory Mental Health Council, to public and other nonprofit institutions, but only to the extent necessary for the purposes of such training and instruction."

HEALTH CONFERENCES

SEC. 8. Section 312 of the Public Health Service Act is amended to read as follows:

"HEALTH CONFERENCES

"SEC. 312. A conference of the health authorities of the several States shall be called annually by the Surgeon General. Whenever in his opinion the interests of the public health would be promoted by a conference, the Surgeon General may invite as many of such health authorities to confer as he deems necessary or proper. Upon the application of health authorities of five or more States it shall be

the duty of the Surgeon General to call a conference of all State and Territorial health authorities joining in the request. Each State represented at any conference shall be entitled to a single vote. Whenever at any such conference matters relating to mental health are to be discussed, the mental health authorities of the respective States shall be invited to attend."

GRANTS TO STATES

SEC. 9. (a) Subsection (c) of section 314 of the Public Health Service Act is amended to read as follows:

"(c) To enable the Surgeon General to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate public health services, including grants for demonstrations and for the training of personnel for State and local health work, there is hereby authorized to be appropriated for each fiscal year a sum not to exceed $30,000,000. Of the sum appropriated for each fiscal year pursuant to this subsection there shall be available an amount, not to exceed $3,000,000, to enable the Surgeon General to provide demonstrations and to train personnel for State and local health work and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist States in carrying out the purposes of this subsection."

(b) Subsection (d) of such section is amended to read as follows:

"(d) For each fiscal year, the Surgeon General, with the approval of the Administrator, shall determine the total sum from the appropriation under subsection (a), the total sum from the appropriation under subsection (b), and, within the limits specified in subsection (c), the total sum from the appropriation under that subsection which shall be available for allotment among the several States. He shall, in accordance with regulations, from time to time make allotments from such sums to the several States on the basis of (1) the population, (2) the extent of the venereal-disease problem, the extent of the tuberculosis problem, and the extent of the mental health problem and other special health problems, respectively, and (3) the financial need of the respective States. Upon making such allotments the Surgeon General shall notify the Secretary of the Treasury of the amounts thereof."

(c) Subsection (f) of such section is amended to read as follows:

"(f) The moneys so paid to any State shall be expended solely in carrying out the purposes specified in subsection (a), or subsection (b), or subsection (c) of this section, as the case may be, and in accordance with plans, approved by the Surgeon General, which have been presented by the health authority of such State and, to the extent any such plan contains provisions relating to mental health, by the mental health authority of such State."

(d) Subsection (h) of such section is amended to read as follows:

"(h) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the health authority or, where appropriate, the mental health authority of the State, finds that, with respect to money paid to the State out of appropriations under subsection (a), or subsection (b), or subsection (c), as the case may be, there is a failure to comply substantially with either—

"(1) the provisions of this section;

"(2) the plan submitted under subsection (f); or

"(3) the regulations;

the Surgeon General shall notify such State health authority or mental health authority either that further payments will not be made to the State from appropriations under such subsection (or in his discretion that further payments will not be made to the State from such appropriations for activities in which there is such failure), until he is satisfied that there will no longer be any such failure. Until he is so satisfied the Surgeon General shall make no further certification for payment to such State from appropriations under such subsection, or shall limit payment to activities in which there is no such failure."

(e) Subsection (i) of such section is amended to read as follows:

"(i) All regulations and amendments thereto with respect to grants to States under this section shall be made after consultation with a conference of the State health authorities and, in the case of regulations or amendments which relate to or in any way affect grants under subsection (e) for work in the field of mental health, the State mental health authorities. Insofar as practicable, the Surgeon General shall obtain the agreement, prior to the issuance of any such regulations or amendments, of the State health authorities and, in the case of regulations or amendments which relate to or in any way affect grants under subsection (e) for work in the field of mental health, the State mental health authorities."

GIFTS

SEC. 10. Section 501 (e) of the Public Health Service Act is amended to read as follows:

"(e) Donations of $50,000 or over in aid of research may be acknowledged by the establishment of suitable memorials to the donors, within the National Institute of Health or, where appropriate, within the National Institute of Mental Health."

NATIONAL INSTITUTE OF MENTAL HEALTH

SEC. 11. There is hereby authorized to be appropriated a sum not to exceed $7,500,000 for the erection and equipment, for the use of the Public Health Service in carrying out the provisions of this Act, of suitable and adequate hospital buildings and facilities, including necessary living quarters for personnel, and of suitable and adequate laboratory buildings and facilities, and such buildings and facilities shall be known as the National Institute of Mental Health. The Federal Works Administrator is authorized to acquire, by purchase, condemnation, donation, or otherwise, a suitable and adequate site or sites, selected on the advice of the Surgeon General of the Public Health Service, in or near the District of Columbia for such buildings and facilities, and to erect thereon, furnish, and equip such buildings and facilities. The amount authorized to be appropriated in this section shall include the cost of preparation of drawings and specifications, supervision of construction, and other administrative expenses incident to the work: *Provided*, That the Federal Works Agency shall prepare the plans and specifications, make all necessary contracts, and supervise construction.

Approved July 3, 1946.

The Hospital Survey and Construction Act

With the signing by the President of the Hospital Survey and Construction Act, an appropriation of 375,000,000 dollars is authorized during the next five years for the construction of hospitals and health centers. Three million dollars is also authorized for state-conducted surveys of need. These must be made preliminary to the granting of federal funds for construction.

The act provides latitude for each state to develop its own program of hospital and health-center construction, to be administered by state authorities under standards specified by the United States Public Health Service. The Surgeon General will be assisted in establishing standards by a newly created federal hospital council consisting of eight members to be appointed by the Federal Security Administrator.

"This act sets for the first time a national policy which makes it clear that hospitals in the future must be planned, located, and operated in relation to the over-all health needs of the people," Thomas Parran, Surgeon General, U. S. Public Health Service, said. "This policy, as evolved through the leadership of hospital authorities of the country, is recognition of the integrated rôle that hospitals and health centers must play in the future. Adequate hospitals, health centers, and related physical facilities are the essential workshops without which it is not possible to provide even a minimum of modern health and medical services."

Any state may initiate action by submitting a request to the Surgeon General for funds to carry out an inventory of existing hospitals, and to prepare a plan for the construction necessary to provide adequate care for all the people. In making the request, the states must designate a single state agency to carry out the survey and planning, and must appoint a properly qualified advisory council to consult with the state agency. The proportionate share for each state of the total federal appropriation for survey and planning will be determined by the populations of the several states. However, federal funds must be matched by two to one in defraying the survey expenses.

Allotments for the actual construction of facilities will not be made until the state plan based on the survey findings has been approved. Construction allotments to individual states will vary in amount. Population will be one factor, and in addition, the average per capita income will be used in the allotment formula in such a way that states with a lower per capita income, where there is relatively greater need for medical facilities, will receive proportionately larger allotments per capita.

Applications for funds for individual construction projects must be channeled through the designated state agency. Here, again, federal funds may not exceed one-third of the cost of a project. Before any single project is approved by the Surgeon General, sufficient evidence must accompany the building request to show that two-thirds of the total cost of construction is available from other-than-federal sources, and that financial support is adequate for the maintenance and operation of the institution after completion.

Plans Available for Psychiatric Wards in General Hospital

The Hill-Burton Bill (S. 191) making it possible for the federal government to provide grants in aid to states for the construction of hospitals is now law, and state commissions are being set up in order to formulate plans to be submitted to Washington for support. These commissions should include representatives of the mental-hygiene field, especially since mental hospitals include approximately half of all hospital beds, and most general hospitals are without psychiatric facilities.

To facilitate the inclusion of psychiatric facilities in general hospitals, the United States Public Health Service has drawn suggestive architectural plans and blueprints which may be used by those who are interested in the construction of general hospitals. These can be obtained from the U. S. Public Health Service, Washington, D. C.

Dr. Parran Stresses Importance of Mental Hygiene in World Health Plans

In his closing address before the International Health Conference in New York, July 22, Dr. Thomas Parran, Surgeon General of the United States Public Health Service and President of the International Health Conference, mentioned mental illness along with cancer, heart disease, and degenerative diseases as one of the "obvious targets" for international scientific endeavor, and emphasized the basic importance of mental hygiene in any plan for world health.

To quote the final remarks of his address, which is published in full in the *Journal of the American Medical Association* of August 10, Dr. Parran said:

> "A next step toward world health is the positive improvement of health—of physical and mental fitness. Higher levels of physical development, a longer, more productive, more vigorous life span will be sought and attained.
>
> "To help reach these goals not only do we need to apply all the knowledge we now have for prevention, treatment, and control of disease everywhere in the world, but we need to conduct intensive research in

the laboratory, at the bedside, and in the field to push back the frontiers of the unknown in the health sciences.

"These several measurable, scientific objectives are difficult, but not impossible of attainment. Yet at our conference the practical scientists have not been content to stop at this point. We have an additional task.

"Humane plans for world health go for naught unless the peoples of the world can learn to live together in peace. Never again can our world disintegrate into the insanity of another total war.

"Public-health experts realize that our science may be used either to save life or to destroy civilization. Whether science is to be used for good or for evil is not determined by scientists themselves. The same type of research worker may discover penicillin or atomic fission. It is the mass conscience of mankind—the dominance of the moral or the amoral—which determines whether research is to be used for life or death.

"In our Magna Carta for health we have ventured to declare that we have a contribution to make to the central world problem of our day, which is to help man learn to live together harmoniously with his fellow man. In making this proposition I, for one, believe that health science must share the task with religion and education.

"The science of mental hygiene is one of our newer disciplines, concerned with the human mind and emotions. Even in its present early stage of development it helps man adjust to his environment, to live in greater harmony with his family, his community, his world. This science of mental hygiene needs urgently to be developed and applied as a basic element in preventing war and destroying the seeds of war.

"The World Health Organization is, therefore, a collective instrument which will promote physical and mental vigor, prevent and control disease, expand scientific health knowledge, and contribute to the harmony of human relations. In short, it is a powerful instrument forged for peace.

"We return to our homes knowing that we have done our best. We hope that history will record a job well done."

New York Plans State-Wide Modernization of Mental Hospitals

Three years of study and planning by the New York State Department of Mental Hygiene and Governor Dewey's Postwar Public Works Planning Commission have put the department in a position to make the most intensive attack on the problem of mental illness ever undertaken in this state, according to a recent statement by Dr. Frederick MacCurdy, State Commissioner of Mental Hygiene.

Along with the program to modernize and expand the state's institutional facilities, so that overcrowding may be eliminated and provision made for more adequate care of all patients admitted, the department has developed plans to improve the standards of care and treatment as well as of prevention of mental disorders. These plans include: modern medical and surgical buildings at 16 institutions; intensified research into the causes and cure of mental illness; increased use of shock therapies; special provision for the care of tuberculous mental patients at four regional centers; more staff

housing; better training facilities to meet the need for more psychiatric, nursing, and social service personnel; additional clinics for prevention and after-care; extension of family care; improved food service for patients and employees.

The building program for the mental institutions will be the largest item in the state departmental construction program as mapped by the planning commission. As soon as materials and man power become available, the department will launch a program of construction and reconstruction at the state's 28 mental institutions, for which projects estimated to cost over $81,000,000 (on the basis of 1940 building costs) already have been approved by the planning commission.

Dr. MacCurdy points out that the department's planning is in line with Governor Dewey's message to the Legislature, in which he said that "our institutions have been neglected through long years of depression and as a result of the enforced curtailment of building during the war years. Now that the war is over, and as men and materials again become available, we must press forward to meet these moving, human needs."

Overcrowding in the mental institutions has been chronic. To-day it averages 20 per cent, with several institutions more than 30 per cent overcrowded. As Governor Dewey has pointed out, "antiquated buildings, insufficient sanitary facilities, some patients sleeping in corridors—this is the way the proud state of New York at the present time is forced to take care of the unfortunate people in its mental and other institutions. We cannot, we must not, permit these conditions to continue."

Because of the overcrowding and the physical conditions in some of the mental-hygiene institutions, Dr. MacCurdy stated, the construction of new buildings for patients has priority in the department's planning. New construction to increase capacity, or to replace obsolete buildings constituting fire and other hazards, will be undertaken at all but a few of the state's institutions for mental illness, mental deficiency, and epilepsy.

Relief of overcrowding and provision of more adequate physical facilities are the foundation on which better professional care can be built.

Part of the program, it was said, will be one of replacing antiquated and outmoded buildings which will be demolished. It is a long-term program that it will take several years to carry out, but work will be undertaken as rapidly as possible at critical points where the needs are most pressing, especially with reference to medical care facilities and relief of overcrowding.

Foremost in the building program at various institutions through-

out the state is the erection of new medical and surgical buildings to implement the modern conception of care and treatment. In such buildings provision will be made both for the mental and for the physical needs of patients. They will house diagnostic clinics, laboratories, operating suites, schools of nursing, X-ray units, facilities for special treatment, including the shock therapies, offices, and general service rooms.

"In reality," Dr. MacCurdy states, "these new medical and surgical buildings will be the heart of the institution. They will constitute a hospital within a hospital. They will not only make modern classification, study, and treatment possible, but also will serve as centers for research and for the training of psychiatric and nursing personnel."

Other urgent needs are new units for tuberculous mental patients; facilities for children with behavior and personality problems, for whom units will be provided in three additional hospitals; and units for defective children under five years and infants, for whom special facilities will be provided in the state schools. Construction is already under way at Craig Colony to provide additional beds for infirm epileptics.

The department and the Postwar Planning Commission have already announced plans for demolition of the antiquated Manhattan State Hospital on Ward's Island in the East River near New York's populous Boroughs of Manhattan and Bronx and erection of a new $15,000,000 modern institution with accommodations for 3,160 patients.

As of August 15, the Postwar Planning Commission had approved 107 projects for the mental-hygiene department. On the basis of 1940 costs, it is estimated that they will cost over $81,000,000 to construct.

These approved projects will provide some 12,500 new beds for patients. Adding these to the 8,000 beds in buildings that the army took over as general hospitals during the war, there will be available eventually a total of over 20,000 new beds, or an increase of about 25 per cent over existing facilities. This will not only relieve present overcrowding, totaling 14,000 patients, but will provide an expansion of approximately 6,000 beds to care for increased admissions. Over the past fifteen years, this increase has averaged 2,500 patients a year.

The department's total program, including the present approved projects, will eventually provide an additional 18,000 beds for expansion.

Primary attention is being given to buildings to be occupied by patients, but plans have also been made for many new service facilities. The total program contemplates the following new construction

for the housing of patients: 16 medical and surgical and reception units, 10 projects for disturbed patients, 32 projects for infirm patients, 15 projects for patients requiring continued treatment, four projects for tuberculous patients, and three new special units at state hospitals for the treatment of behavior and personality disorders in children. When the projected new facilities are constructed, the state will be able to care for mental defectives of all ages.

The construction of the special units for mental patients with tuberculosis will make better segregation possible and will concentrate specialized treatment facilities for this condition. It will also permit the closing at some institutions of special tuberculosis wards which had to be set up in buildings not planned for that purpose.

Among other important factors is the erection of one-family houses which will provide living accommodations for staff officers and correct an unfortunate condition under which some staff members must live in buildings designed for and being used by patients. Modern facilities for storage and refrigeration are to be furnished at several institutions and power-plant facilities are to be improved and enlarged to accommodate the expansion.

"The program," Dr. MacCurdy concludes, "contemplates new construction at every one of the state's 28 mental institutions, with a view to providing ultimately an efficient, modern plant for the adequate care and treatment of all of the state's mentally afflicted wards."

News of Mental-Hygiene Societies

California

The Board of Directors of the Southern California Society for Mental Hygiene has appointed Mrs. Helene M. Lipscomb as its executive director. Mrs. Lipscomb was formerly Assistant Director of the Los Angeles Veterans Service Center. With a new director, the society is planning an expanded program of public education and integration of activities for mental health.

The Southern California Society will be in its new offices at 600 South Hobart Boulevard, Los Angeles 5, California, after September 15, 1946.

Washington

With the idea of promoting a broad program of mental hygiene for the State of Washington, ways and means for developing such a program have been outlined by the Washington Society for Mental Hygiene in a publication recently issued under the title *Manual on Local Unit Organization*. This manual, according to a recent report of the society's executive secretary, Mr. George F. Ault, has been sent to people in various occupations and professions through-

out the state for the purpose of securing their comments and suggestions regarding its adequacy as a source of information and as a tool for developing a state-wide organization. The manual will then be revised and placed in the hands of individuals and groups in the state who indicate an interest in developing a county program.

Dr. MacCurdy Urges Closer Attention to Tuberculosis in Mental Institutions

In an article in a recent issue of the magazine *Hospitals,* Dr. Frederick MacCurdy, New York State Commissioner of Mental Hygiene, states that tuberculosis is "a problem of first importance in every mental institution." Emphasizing the need for special treatment of the tuberculous among mental patients, Dr. MacCurdy says: "To-day, by the proper segregation of these patients and with the concentration of medical, nursing, and therapeutic facilities in separate units for their medical care, we hope we are on the road to definite reduction of the number of the tuberculous in these institutions." The commissioner is referring to New York State's plans for the establishment, at four strategically located institutions, of centers for the separate care and treatment of mental patients with this disease.

Since 1941 a campaign against tuberculosis in the New York State mental hospitals has been in progress. The article points out that during a survey conducted jointly by the state department of mental hygiene and the state department of health, it was revealed that among 75,658 of the patients in these institutions, 4,133, or 5.6 per cent of those in the mental hospitals, had clinically significant tuberculosis, and 2.4 per cent of those in schools for mental defectives and the colony for epileptics had active or apparently active tuberculosis.

An important feature of the campaign has been the X-raying of every patient upon admission to any of the New York State mental institutions and subsequent X-ray examination at intervals of all the patients and employees. Dr. MacCurdy recommends this as a highly desirable measure, which should have widespread adoption in other states.

Writing of the nation-wide situation, Dr. MacCurdy says, "To date, in mental hospitals there has been very little organized medical care under properly trained physicians and with properly organized facilities to promote the cure of tuberculosis in mental hospitals." To correct this situation he urges closer coöperation between mental-hygiene agencies and departments of health and other agencies in the community.

The article points out that the problems involved in the control

of tuberculosis in state institutions for the care of the mentally ill and the mentally defective have many peculiar variations from those found in general hospitals or in special tuberculosis hospitals treating nonpsychiatric patients. Not least among them is the lack of coöperation by the patients either in examination or in treatment. Moreover, overcrowding in these institutions makes the problem of segregation far from easy.

Dr. MacCurdy notes that while the segregation of tuberculous patients from other mental patients is not new in New York State, since most of its institutions have long had separate tuberculosis pavilions or divisions, because of the special facilities required it is not practicable to have such tuberculosis units in every mental hospital.

Construction of the proposed tuberculosis centers, already approved by the New York State Postwar Public Works Planning Commission, in addition to alleviating overcrowding and promoting the ideal of segregation, will concentrate the department's therapeutic efforts and make possible the provision of the best care and treatment available for this type of patient.

Fewer "Shell-Shock" Cases in World War II

Hysteria—the so-called "shell-shock" of World War I, although probably a majority of its victims never heard a shell fired—persisted on a greatly diminished scale among American troops in the last war, according to an announcement from the Surgeon General's Office.

It was predominantly a mental malady of the last generation. Essentially it is manifested as a syndrome that simulates, without organic basis, some pathological physical condition. A victim will develop, for example, a paralyzed arm, but physical examination shows that the paralyzed area does not follow any single nerve or group of nerves. A man may be suddenly stricken blind, but nothing wrong can be found with his eyes or optic nerve.

A hysteric is not consciously faking. For all practical purposes, his arm is really paralyzed or his eyes sightless. Questioning often will reveal that the victim has had a hard blow on the arm or got a bug in his eye. If such a condition is not recognized, it may persist for years and the organ involved may actually become permanently useless through disuse.

At about the time of World War I this was common enough both among the military and civilians. On the part of the soldier, it was an unconscious flight from danger. A hysterically paralyzed arm was a means of running away without suffering any of the penalties.

Shortly after the war, psychiatrists began to report that no hysterical cases were coming to their offices any more. Instead, they were getting more and more cases of so-called "anxiety neurosis," an overwhelming fear without specific physical manifestations. It was explained that the pattern of reaction of the individual with a somewhat unstable nervous system was changing with the changing times. Hysteria was a disease of a simpler environment.

This persisted into World War II. Many of the younger military psychiatrists never had seen an hysterical case and knew of the condition only through textbooks.

They talked of "anxiety neuroses," "combat fatigue," and the like. For the most part, they were right. But, according to a study just reported by Lieutenant Colonel David B. Davis and Captain John W. Bick, of the Army Medical Corps, about one out of five of more than 1,000 neuropsychiatric cases returned to one American army hospital from overseas was actually a victim of hysteria.

"It is evident," they conclude, "that hysteria was not of infrequent occurrence in World War Two."

Overcrowding at Letchworth Village

A condition of overcrowding that is described as desperate is emphasized in the recent annual report of the Board of Visitors of Letchworth Village, the New York State school for mental defectives at Thiells, New York. In some dormitories, the report states, the figure has reached 50 per cent above rated capacity. Some 300 children sleep on mattresses on the floors of day rooms. The establishment of a new state farm colony, patterned on Letchworth Village, in the New York metropolitan district is urged as the only remedy for this disgraceful situation.

The report endorses Governor Dewey's stand for a humanized civil service and demands better administration of our civil-service laws. It insists that attendants, teachers, firemen, technicians, and other groups be exempted from civil-service control and comments: "It is difficult enough to find capable people to staff our institutions without hampering their directors at every turn by stupid and ill-conceived rules and regulations that destroy the basic conception of service based on merit." Examinations for medical positions, the report recommends, should be thrown open to qualified physicians from all parts of the United States.

The report also endorses with enthusiasm Commissioner Frederick MacCurdy's program for medical and psychiatric residencies.

Pennsylvania Establishes Twelve Research Positions

The Honorable S. M. R. O'Hara, Secretary of Welfare of the Commonwealth of Pennsylvania, announces the establishment of

twelve positions for research in psychiatry and related fields at the Western State Psychiatric Institute and Clinic, Pittsburgh. At the institute numerous clinical and teaching activities, the latter in collaboration with the University of Pittsburgh, have already been initiated.

The institute is the teaching and research hospital of the Pennsylvania mental-hospital system, which includes twenty-one hospitals and institutions with an average of 40,000 patients. Thus access to much clinical material is assured. Here, it is expected, will be trained psychiatrists, social workers, psychologists, nurses, occupational therapists, and others for hospitals and private fields.

The new positions provide for the appointment of properly qualified senior and junior research workers in psychiatry, internal medicine, biochemistry, neuropathology, neurophysiology, and clinical psychology. Several positions as in psychology and neurophysiology are currently filled.

In some instances research at the institute will be coördinated with teaching at the university; in such case the applicant for appointment, and his qualifications, must meet also with the approval of the dean of the school of medicine.

Interested persons may obtain further information by writing to the director of the institute, Grosvenor B. Pearson, M.D., O'Hara and DeSoto Streets, Pittsburgh 13, Pennsylvania.

Funds Available for Psychosomatic Research

The Psychosomatic Research Fund of The National Committee for Mental Hygiene announces that funds are available for projects dealing with the psychosomatic study of cardiovascular disease, including essential hypertension. Communications should be addressed to Dr. Edward Weiss, Director, 269 South 19th Street, Philadelphia 3, Pa.

"Education for Responsible Parenthood"

A program to promote better understanding of the sex development of children and adolescents among parents, teachers, and youth-group leaders, so that they may be equipped to give children information about themselves and the opposite sex in a frank and honest way, has been instituted by the Mississippi Social Hygiene Association. "Education for Responsible Parenthood," as the movement is called, was the outgrowth of a general recognition, by those who have to do with young people, of the need for taking steps to combat the high prevalence of sex delinquency and irregularities of behavior resulting from war and post-war conditions.

The program has enlisted the interest not only of parents and

teachers, but of community agencies of many types—health and welfare organizations, the Y.M.C.A. and the Y.W.C.A., the Hi-Y, the 4-H Club, the Boy Scouts, churches and synagogues, women's clubs, and other agencies.

During the last year the association has held over one hundred institutes for parents, has trained five hundred teachers in local communities and at summer sessions, and has discussed its program at conventions, meeting, and institutes before four thousand people. Five Leadership Training Institutes were held and attended by two hundred leaders of social agencies, who are carrying on discussion groups in their own communities. During the past summer, at the University of Mississippi, Mississippi Southern, and Delta State Teachers College, two hundred and twenty-six teachers attended a six-weeks session on "Mental and Emotional Growth" and another three hundred were given orientation talks. Nine of the colleges in the state are giving courses in "Family Living" this semester and it is hoped that the other two will introduce such courses in February.

In addition, the association has prepared an "E.R.P. Kit" for the use of its leaders. Three thousand of these kits have been distributed and have met with such popularity that the material is now to be printed. It will be issued in pamphlet form for distribution within the state and in book form for out-of-state consumption.

Mental-Hospital Administration Course Inaugurated

A course in hospital administration and management, with major emphasis on mental hospitals, was inaugurated by the New York State Department of Mental Hygiene on September 26. The course, which will run for ten months, will consist of monthly sessions, to be held on the final Thursday of each month in Hearing Room #2 in the Governor Alfred E. Smith State Office Building.

It will be open not only to associate directors and administrative assistant directors of the institutions in the department of mental hygiene, but also to administrative officers of the institutions of the departments of health and correction.

In announcing the project, Dr. Frederick MacCurdy, Commissioner of Mental Hygiene, recalled that Governor Thomas E. Dewey, in a recent address to the employees of the Marcy State Hospital, stressed the fact that the director of a mental hospital needed to be a "jack of all trades and master of many." The governor elaborated this point by emphasizing the requirement that the director be first a good psychiatrist. Because the institution is also a little community in itself, other necessary talents include, he said, a working knowledge of personnel administration, public relations, business

practice, farming, engineering, laundering, baking, food preparation, maintenance, housekeeping, and other phases of institutional management.

A detailed course has, therefore, been laid out which will progressively take up both the theory and the practical management of hospital care. This will involve not only the theory and practice of all of the divisions of professional care, including therapeutic rehabilitation, social service, and other phases, but will carry through to all of the maintenance departments, such as laundries, kitchens, farms, business offices, and so on.

Lectures and discussions will be led by experts in their fields both from within and from without the state services. The course will emphasize the practical over the theoretical considerations of hospital management in order to stimulate efforts toward raising the standards of mental-hospital administration to levels comparable with those of the best modern general hospitals.

Annual Seminar on Reading Disabilities

The 1947 Annual Seminar on Developmental Reading will be conducted by the Reading Clinic Staff, Department of Psychology, Temple University, from February 3 to February 7, inclusive. Lectures, demonstrations, and discussions will be used to develop the central theme: Differentiated Corrective and Remedial Reading.

Topics for successive days are: Approaches to Analysis of Reading Disabilities, The Analysis Program, Case History, Social and Emotional Correlates, Physical and Neurological Factors, Capacity for Reading, Reading and General Language Achievement, Classification of Reading Problems, Remedial and Corrective Procedures. The activities of the institute will be differentiated to meet the needs of classroom teachers, remedial teachers, school psychologists, supervisors, administrators, neurologists, and vision specialists.

Nationally known specialists in reading and related fields will conduct the seminars and demonstrations.

Enrollment is limited by advanced registration. For copies of the program and other information regarding this one-week institute, write to Dr. Emmett Albert Betts, Reading Clinic, Temple University, Philadelphia 22, Pennsylvania.

Annual Meeting of Group Therapy Association

The annual meeting of the American Group Therapy Association will be held in New York City in January, 1947. The program will include a session on group therapy in private practice; a session on parallel treatment of a group of pre-school children with a group of their mothers; a session on research in group therapy; and a report on a training program for workers in group therapy.

Recovery, Inc., Establishes Monthly Journal

The first issue of a new monthly magazine, *Recovery Journal,* made its appearance in June. The journal, which is described on its cover as "a monthly magazine for the study of self-help methods in the treatment of nervous and former mental patients," is published by Recovery, Inc., of Chicago, the association of recovered mental patients who formerly published *Lost and Found.* Dr. Abraham Low, editor of *Lost and Found,* which ceased publication in 1941, is the editor of the new journal also.

The aim of Recovery, Inc., as stated in the journal, is to prevent relapses in mental disease and to combat chronicity in nervous ailments. Its techniques are those of group treatment with the emphasis on self-help.

The price of a subscription to *Recovery Journal* is $2.00 a year, $1.00 for members of the organization, whose present quarters are at 185 North Wabash Avenue, Chicago 1, Illinois.

Seton Institute

Announcement has been made that the reorganization program of the Mount Hope Retreat in Baltimore and the formation of the Seton Institute for acute and recoverable cases are progressing rapidly and satisfactorily. Dr. C. H. Rogerson, formerly Medical Superintendent of Cassel Hospital at Swaylands, England, has been elected medical director and is now taking an active part in the reorganization plans.

The rehabilitation of certain sections of the hospital has been completed and patients are now being admitted under the new organization. There are several vacancies on the staff, especially for junior psychiatrists and for interns who are seeking opportunities for training in psychiatry.

Brigadier General William C. Menninger Separated from Army

Brigadier General William C. Menninger, former Director, Neuropsychiatry Consultants Division, Office of The Surgeon General, was returned to civilian life June 27, after three and one-half years service.

Commissioned a lieutenant colonel, M.C., on November 10, 1942, General Menninger served as neuropsychiatric consultant for the Fourth Service Command eleven months. He was assigned to the Office of The Surgeon General on December 10, 1943, in the same position he held prior to his discharge.

Before his departure, Major General Norman T. Kirk, The Surgeon General, presented him with the Army Commendation Ribbon for his services as "Chief Consultant in Neuropsychiatry to the Surgeon

General and as Director, Neuropsychiatry Consultants Division, from November 20, 1945, until June 28, 1946." General Menninger will continue as Chief Consultant in a civilian capacity.

He received the Distinguished Service Medal early this year. The citation stated that "through his superior judgment, professional knowledge, and inspiring leadership, the problem of neuropsychiatry in this war has been solved in a manner of which the army and the nation can well be proud." Under his leadership, also, the program of preventive psychiatry was established in the army.

On November 9, 1944, General Menninger was selected as the first recipient of the Lasker Award "for the most outstanding contribution to the mental health of the men and women of our armed forces."

General Menninger expects to return to his former practice as Medical Director of the Menninger Psychiatric Hospital, Topeka, Kansas, a position he held from 1930 until he was commissioned in the army. During World War I, he was a second lieutenant in the infantry.

Salmon Lectures for 1946

Dr. David M. Levy, prominent New York Psychiatrist, has been named by The Salmon Committee on Psychiatry and Mental Hygiene of the New York Academy of Medicine as the Salmon Lecturer for 1946. Entitled "Excursions in the New Fields of Psychiatry," his lectures will be given on three successive Wednesday evenings—November 6, November 13, and November 20—in the New York Academy of Medicine Building, 2 East 103rd Street, New York City. Members of the medical profession and their friends are invited to attend.

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